STATE OF DELAWARE

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Management Services
1901 N. DuPont Highway
New Castle, DE 19720

REQUEST FOR PROPOSAL NO. HSS-10-102

FOR

ASSESSMENTS OF ALL RESIDENTS IN PUBLIC INSTITUTIONS FOR COMMUNITY-BASED CARE

FOR

THE DIVISION OF MEDICAID & MEDICAL ASSISTANCE
DELAWARE HEALTH AND SOCIAL SERVICES
HERMAN M. HOLLOWAY SR. CAMPUS
1901 N. DUPONT HIGHWAY
NEW CASTLE, DE. 19720

Deposit	Waived
Performance Bond	Waived

Date Due: December 17, 2010
12:00 P.M. LOCAL TIME

There is no mandatory pre-bid meeting for this Request for Proposal.

REQUEST FOR PROPOSAL # HSS-**10-102**

Bids for the **Assessment Project** for the Division of Medicaid & Medical Assistance will be **received** by the Delaware Health and Social Services, Herman M. Holloway Sr. Campus, Procurement Branch, Main Administration Building, Sullivan Street, Second Floor, Room #257, 1901 North DuPont Highway, New Castle, Delaware 19720, until **December 17, 2010 at 12:00 p.m.** At which time the proposals will be opened and read.

There is no mandatory pre-bid meeting for this proposal.

All RFPs can be obtained online at http://bids.delaware.gov
A brief cover letter must be submitted with your proposal. Specifications and administration procedures may be obtained at the above office or phone (302) 255-9290.

NOTE TO VENDORS: Your proposal must include the forms in Appendices A, B ,C and D signed and all information on the forms complete.

NOTIFICATION TO BIDDERS

Bidder shall list all contracts awarded to it or its predecessor firm(s) by the State of Delaware; during the last three years, by State Department, Division, Contact Person (with address/phone number), period of performance and amount. The Evaluation/Selection Review Committee will consider these Additional references and may contact each of these sources. Information regarding bidder performance gathered from these sources may be included in the Committee's deliberations and factored in the final scoring of the bid. Failure to list any contract as required by this paragraph may be grounds for immediate rejection of the bid."

There will be a ninety (90) day period during which the agency may extend the contract period for renewal if needed.

If a bidder wishes to request a debriefing, they must submit a formal letter to the Procurement Administrator, Delaware Health and Social Services, Main Administration Building, Second Floor, South Loop, 1901 North DuPont Highway, Herman M. Holloway Sr., Health and Social Services Campus, New Castle, Delaware 19720, within ten (10) days after receipt of "Notice of Award". The letter must specify reasons for the request.

If you do not intend to submit a bid you are asked to return the face sheet with "NO BID" stated on the front with your company's name, address and signature.

IMPORTANT: ALL PROPOSALS MUST HAVE OUR RFP NUMBER HSS-**10-102** ON THE OUTSIDE ENVELOPE. IF THIS NUMBER IS OMITTED YOUR PROPOSAL WILL IMMEDIATELY BE REJECTED.

FOR FURTHER BIDDING INFORMATION PLEASE CONTACT:

BRUCE KRUG
DELAWARE HEALTH AND SOCIAL SERVICES
PROCUREMENT BRANCH
MAIN ADMIN BLD, SULLIVAN STREET
2ND FLOOR –ROOM #257
1901 NORTH DUPONT HIGHWAY
HERMAN M. HOLLOWAY SR. HEALTH AND
SOCIAL SERVICES CAMPUS
NEW CASTLE, DELAWARE 19720
PHONE: (302) 255-9290

IMPORTANT: DELIVERY INSTRUCTIONS

IT IS THE RESPONSIBILITY OF THE BIDDER TO ENSURE THAT THE PROPOSAL HAS BEEN RECEIVED BY THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES BY THE DEADLINE.

The issuance of this Request for Proposals (RFP) neither commits the Delaware Department of Health and Social Services, Division of Medicaid & Medical Assistance to award a contract, to pay any costs incurred in the preparation of a proposal or subsequent negotiations, nor to procure or contract for the proposed services. The Division reserves the right to reject or accept any or all proposals or portion thereof, to cancel in part or in its entirety this Request for Proposals, or to delay implementation of any contract which may result, as may be necessary to meet the Department's funding limitations and processing constraints. The Department and Division reserve the right to terminate any contractual agreement without prior notice in the event that the State determines that State or Federal funds are no longer available to continue the contract.

REQUEST FOR PROPOSAL FOR THE ASSESSMENT PROJECT
FOR
THE DIVISION OF MEDICAID & MEDICAL ASSISTANCE

Availability of Funds

A maximum of **$100,000** is available for the selected vendor to provide services in the area of conducting Assessments of all Residents in Public Institutions. Contract term is for one (1) year with the possibility of renewal for up to two (2) optional years contingent on funding and additional needs to be addressed.

Pre-Bid Meeting

A pre-bid meeting is not required.

Further Information

Inquiries regarding this RFP should be addressed to:

Daniese McMullin-Powell
Social Service Administrator
The Division of Medicaid & Medical Assistance
The Herman Holloway Campus
1901 North Dupont Highway
The Lewis Building
New Castle, DE 19720
Phone: (302) 255-9635
Fax: (302) 255-4413
Daniese.McMullin-Powell@state.de.us

Restrictions on Communications with State Staff

From the issue date of this RFP until a contractor is selected and the selection is announced, bidders are NOT allowed to contact any Division of Medicaid & Medical Assistance staff, except those specified in this RFP, regarding this procurement. Contact between contractors and the Division of Medicaid & Medical Assistance is restricted to emailed or faxed questions concerning this

proposal. Questions must be submitted in writing and will be addressed in writing.

Questions are due by November 12, 2010. The complete list of questions and their answers will be released via e-mail or fax to the vendors that submitted any questions. The complete list of questions and their answers will also be posted on the internet at http://bids.delaware.gov. After November 12, 2010 no further questions will be accepted by Daniese McMullin-Powell.

Administrative questions arising after November 12th can be addressed to Bruce Krug, Procurement Administrator, by calling the Procurement Office at (302) 255-9290 or by e-mail: bruce.krug@state.de.us

REQUEST FOR PROPOSAL FOR THE ASSESSMENT PROJECT
FOR
THE DIVISION OF MEDICAID & MEDICAL ASSISTANCE

I. INTRODUCTION

A. Background

This is a Request for Proposal (RFP) for the Assessment Project issued by Delaware Department of Health and Social Services, Division of Medicaid & Medical Assistance (henceforth referred to as "The Division").

The Mission of the Division of Medicaid & Medical Assistance is to improve health outcomes by ensuring that the highest quality medical services are provided to the vulnerable populations of Delaware in the most cost effective manner. Through innovation, enhance medical coverage to meet the diverse needs of Delawareans, is the vision of the division.

The Division is committed to the development and delivery of community based services, which maximize independence through individual choice in the least restrictive environment possible enabling individuals to continue living active and productive lives, and protecting those who may be vulnerable or at risk.

The Assessment Project is an important component of the ***Finding a Way Home*** program, Delaware's Money Follows the Person Demonstration program, which is operated by the Division. The MFP program provides intensive supportive services for adults moving out of institutional long-term care facilities to live in their own homes and other community settings.

Additional information about the Division may be found on the Division's website at www.dhss.delaware.gov/dmma.

B. Project Goals

The Division needs to contract for an agency to conduct assessments of all residents in state-operated institutions utilizing components of an assessment instrument specified by the Division. The purpose of this RFP is to procure the services of a qualified agency to conduct these assessments for approximately 650 residents in state-operated facilities for the period from ***March 1, 2011*** *to* ***February 28, 2012****. The contract may be renewed for two (2) optional years contingent on funding and additional needs to be addressed. This program is funded through a Federal grant*

This is a new component of Delaware's existing Money Follows the Person program, which became operational in July 2008 and is anticipated to provide services to approximately 100 individuals over the course of the project.

The primary goals of the Assessment Project are to:

1. Utilize components of an assessment instrument specified by the Division to complete assessments on all individuals residing in state-operated institutions. These institutions include:
    - Emily Bissell Hospital
    - Delaware Hospital for the Chronically Ill
    - Governor Bacon Center
    - The Stockley Center
    - Delaware Psychiatric Center

The Contractor agency will employ, either directly or by contract, one or more qualified individuals who have the education, training and experience specified in this RFP, to conduct these assessments using components of the assessment instrument provided by the Division.

II. SCOPE OF SERVICES

° All components listed in this section are mandatory.

The Assessment Project

1.0 **Conducting Assessments of All Residents of State-Operated Institutions**
The purpose of the assessments is to determine which facility residents are interested in and able to return to the community and can be accommodated in the community with available supports.

1.1 The Contractor will employ, either directly or by contract, one or more qualified individuals, who have the education, training and experience as outlined below, to conduct assessments of all residents in state-operated institutions, utilizing Division-specified components of an assessment instrument provided by the Division.

The contractor and any subcontractor conducting the assessments must have the following qualifications:

1.1.1 Experience with the multiple populations being served including those who are elderly, physically disabled,

developmentally disabled, and/or those with mental health challenges.

1.1.2 Experience in assessing, planning, developing, implementing, monitoring, and evaluating options and services to meet an individual's human service needs using effective counseling or interviewing techniques as well as other available resources such as service plans or case management systems.

1.1.3 Skill in interviewing, oral and written communication and interpersonal relations for effective interactions with client/family providers and agencies.

1.1.4 Knowledge of community services, resources and standards of health care and service delivery.

1.1.5 Ability to gather, compile, and record, information for comprehensive statistical and narrative reports and summaries as required.

1.2 The State's current assessment instrument can be found in Appendix G. The State is currently in the process of revising its assessment instrument. The Division will provide the Contractor with the revised assessment instrument and will specify which components of the assessment instrument the Contractor will be required to complete.

Examples of components that the Contractor would be required to complete if the current assessment instrument were to be used include the following:

- Section A of the Cover Sheet
- The following portions of Section 1 Physical Health Evaluation
  A. Client Interview
  B. Self-Rated Health
  D. Current Health Status
- Section 2 IADL's
- Section 4 Activities/Social Environment
- Section 6 Social Background
- Section 7, C Behavioral symptoms, factors & observations that impact care needs.
- Section 9 Informal Supports/Caregivers

1.3 The Division will provide the Contractor with a list of all residents in the state-operated institutions.

1.4 The Contractor is required to contact the administrators of all the following state-operated institutions to coordinate the scheduling of the resident assessments:

- Governor Bacon Health Center
- Emily Bissell Hospital
- Delaware Hospital for the Chronically Ill
- The Stockley Center
- The Delaware Psychiatric Center

1.5 The Contractor is required to meet with each resident or their legal guardian to obtain written permission to complete the assessment.

1.6 Upon receiving written permission, the Contractor must complete the assessment using Division-specified components of the assessment instrument provided by the Division. The Contractor must utilize information obtained by the resident, facility, staff, residents' family members and the resident's medical records in completing the assessment.

1.7 As part of the assessment the Contractor must identify those residents that:

- Have been a resident in a facility for at least 3 consecutive months.
- Are interested in returning to the community.
- Are in need of affordable, accessible housing in order to return to the community.
- Are in receipt of Medicaid or eligible for Medicaid.

2.0 Reporting

The Contractor will be required to provide the following information and reports to Division in the format specified by Division.

2.1 Provide the Assessment Project Director with a copy of all residents' completed assessments.

2.2 Provide the Project Director with project status monthly reports. These reports will include the following information:

- The number of assessments completed and the name and location of the individuals for whom the assessments were completed

- A short summary that gives information regarding the progress made toward completing the assessments.
- The number of residents in receipt of Medicaid
- The name of each resident and the number of residents not in receipt of Medicaid.
- The number of residents in need of accessible, affordable housing in order to return safely to the community. The price range and type of the housing needed and the county in which the housing is needed (New Castle, Kent or Sussex County)
- In addition, these reports will outline resolved and unresolved issues and/or problems, with suggestions for resolution.

2.3 In addition to these written reports, the Contractor may be required to participate in meetings, conference telephone calls or briefings scheduled by the Division.

2.4 Financial Reports – The Contractor is required to maintain documentation of actual and allowable expenses incurred for services delivered under this contract that will be used for billing/payment and for evaluation of this project.

2.5 The Contractor is required to maintain records to ensure efficient management of the Project review process, budgeting requirements and other information as determined by the Division.

3.0 BILLING UNIT

3.1 The Contractor will be paid for each completed assessment on a per assessment basis.

3.2 All costs for conducting the assessments, including the cost of travel to and from the client's residence, must be included in the vendor's requested rate for conducting the assessment.

4.0 ADMINISTRATIVE REQUIRMENTS

4.1 The contractor must meet and comply with all applicable federal, state and local rules, regulations and standards applying to the services being provided.

4.2 For each resident assessed, the contractor shall establish and maintain case files, which includes the following:

4.2.1 The Informed Consent form signed by the resident or the resident's legal representative;

4.2.2 Documentation of all visits and telephone contacts with the facilities and residents;

4.2.3 The completed assessment.

4.3 The contractor must ensure access to authorized representatives of Delaware Health and Social Services to the residents' case files.

4.4 The contractor must maintain the resident's right of privacy and confidentiality.

5.0 MONITORING REQUIREMENTS

The contractor is obligated to meet the following requirements:

5.1 Monitor the progress and quality of the assessments completed by contractor personnel or subcontractors;

5.2 Monitor time sheets by contractor or subcontractor personnel to ensure they are submitted in a timely fashion and accurately reflect the hours and responsibilities of those conducting the assessments.

6.0 INVOICING REQUIREMENTS

6.1 The providers will invoice DMMA on a monthly basis.

6.2 The following information will also be included on the invoices:

6.2.1 Name and location of each resident assessed in that month.

6.2.2 The completed assessments must be attached to the invoice.

III. SPECIAL TERMS AND CONDITIONS

A. Length of Contract

Contract term is for one (1) year with the possibility of renewal for up to two (2) optional years contingent on funding and additional needs to be addressed.

B. Subcontractors

The use of subcontractors will be permitted for this project. If a subcontractor is going to be used, this needs to be specified in the proposal, with an identification of the proposed subcontractor, the service(s) to be provided, and its qualifications to provide such service(s). Subcontractors will be held to the same requirements as the primary contractor. The contract with the primary contractor will bind sub or co-contractors to the primary contractor by the terms, specifications, and standards as specified in this RFP and any subsequent proposals and standards presented by the Division. All such terms, specifications, and standards shall preserve and protect the rights of the agency under the RFP and any subsequent proposals and contracts with respect to the services performed by the sub or co-contractor, so that the sub or co-contractor will not prejudice such rights. Nothing in the RFP shall create any contractual relation between any sub or co-contractor and the agency.

The proposed subcontractors must be approved by the Division of Medicaid & Medical Assistance.

C. Funding Disclaimer Clause

Delaware Health and Social Services reserves the right to reject or accept any bid or portion thereof, as may be necessary to meet the Department's funding limitations and processing constraints. The Department reserves the right to terminate any contractual agreement upon fifteen (15) calendar days written notice in the event the state determines that state or federal funds are no longer available to continue said contractual agreement.

Please note that a maximum of $100,000 in funding is available for this Assessment project.

D. Reserved Rights

Notwithstanding anything to the contrary, the Department reserves the right to:

- Reject any and all proposals received in response to this RFP;
- Select a proposal other than the one with the lowest cost;
- Waive or modify any information, irregularities, or inconsistencies in proposals received;
- Negotiate as to any aspect of the proposal with the bidder and negotiate with more than one bidder at a time;
- If negotiations fail to result in an agreement within two (2) weeks, the Department may terminate negotiations and select the most responsive bidder, prepare and release a new RFP, or take such other action as the Department may deem appropriate.

E. Termination Conditions

The Department may terminate the contract resulting from this RFP at any time that the vendor fails to carry out its provisions or to make substantial progress under the terms specified in this RFP and the resulting proposal.

Prior to taking the appropriate action as described in the contract, the Department will provide the vendor with thirty (30) days notice of conditions endangering performance. If after such notice the vendor fails to remedy the conditions contained in the notice, the Department shall issue the vendor an order to stop work immediately and deliver all work and work in progress to the State. The Department shall be obligated only for those services rendered and accepted prior to the date of notice of termination.

The Contract may be terminated in whole or part:

a) by the Department upon five (5) calendar days written notice for cause or documented unsatisfactory performance,

b) by the Department upon fifteen (15) calendar days written notice of the loss of funding or reduction of funding for the stated Contractor services,

c) by either party without cause upon thirty (30) calendar days written notice to the other Party, unless a longer period is specified.

F. Contractor Monitoring/Evaluation

The contractor may be monitored/evaluated on-site on a regular basis. Failure of the contractor to cooperate with the monitoring/evaluation process or to resolve any problem(s) identified in the monitoring/evaluation may be cause for termination of the contract.

G. Payment:

The agencies or school districts involved will authorize and process for payment each invoice within thirty (30) days after the date of receipt. The contractor or vendor must accept full payment by procurement (credit) card and or conventional check and/or other electronic means at the State's option, without imposing any additional fees, costs or conditions.

H. W-9 Information Submission

Effective January 5, 2009, a new vendor process and use of the new Delaware Substitute Form W-9 will be implemented by the Delaware Division of Accounting. With the development of the new Delaware Substitute Form W-9, state organizations will no longer be responsible for collecting the Form W-9 from vendors. The vendor will have the capability of submitting the required Form W-9 electronically and directly to the Delaware Division of Accounting for approval. The vendors will submit their Form W-9 by accessing this website, http://accounting.delaware.gov/. The vendor will complete the secure form, read the affirmation, and submit the form by clicking the "Submit" button. Delaware Division of Accounting staff will review the submitted form for accuracy, completeness, and standardization. Once all the requirements are met, the form will be uploaded to the vendor file and approved. The vendor is then able to be paid for services provided.

For those vendors that do not have internet access, a printable version of the Delaware Substitute Form W-9 can be faxed or mailed to the vendor. Upon completion, the vendor will then fax or mail the form directly to the vendor staff at the Delaware Division of Accounting. All vendor requests, additions and changes, will come directly from the vendor. Questions for vendors who do not have internet access, contact vendor staff at (302) 734-6827.

This applies only to the successful bidder and should be done when successful contract negotiations are completed. It is not a required to be done as part of the submission of the bidder's proposal.

IV. FORMAT AND CONTENT OF RESPONSE

Proposals shall contain the following information, adhering to the order as shown:

A. Bidder's Signature Form

This form, found in the Appendix A, must be completed and signed by the bidder's authorized representative.

B. Title Page

The Title page shall include: 1) the RFP subject; 2) the name of the applicant; 3) the applicant's full address; 4) the applicant's telephone number; 5) the name and title of the designated contact person; and 6) bid opening date of December 17, 2010.

C. Table of Contents

The Table of Contents shall include a clear and complete identification of information presented by section and page number.

D. Confidential Information

The following items, if required in response to this RFP, are to be included in a separate section of your proposal and marked as confidential. These items are: 1) any financial information relating to the company or organization (not the RFP pricing or budget); 2) Resumes; 3) Organization Charts (4) Proprietary processes or methods.

E. Qualifications and Experience

This section shall contain sufficient information to demonstrate experience and staff expertise to carry out the project. A statement must be included that the vendor either has or certifies he/she will secure a Delaware Business License prior to initiation of the project. Attach articles of incorporation and IRS certification of tax exempt status if applicable.

The specific individuals who will work on this project must be identified, along with the nature and extent of their involvement. The qualifications of these individuals shall be presented (in resumes or other formats). If conducting this project will require hiring of one or more individuals who are not currently employed by the bidding organization, applications shall provide detailed job descriptions, including required qualifications and experience.

If subcontractors are to be used, the proposal shall also contain similar information regarding each subcontractor.

F. Bidder References

The names and phone numbers of at least three (3) organizations/agencies for whom the vendor carried out a similar project must be included. If no similar project has been conducted, others requiring comparable skills can be used.

Bidder shall list all contracts awarded to it or its predecessor firm(s) by the State of Delaware; during the last three years, by State Department, Division, Contact Person (with address/phone number), period of performance and amount. The Evaluation/Selection Review Committee will consider these additional references and may contact each of these sources. Information regarding bidder performance gathered from these sources may be included in the Committee's deliberations and factored in the final scoring of the bid. Failure to list any contract as required by this paragraph may be grounds for immediate rejection of the bid.

G. Proposed Methodology and Work Plan

This section shall describe in detail the approach that will be taken to carry out the activities described in the Scope of Services section of this RFP. Specific completion dates for the various tasks must be shown. The workplan shall outline specific objectives, activities and strategies, and resources.

H. Statements of Compliance

The bidder must include statements that the applicant agency complies with all Federal and Delaware laws and regulations pertaining to equal opportunity and affirmative action. In addition,

compliance must be assured in regard to Federal and Delaware laws and regulations relating to confidentiality and individual and family privacy in health care delivery and in the collection and reporting of data. (See Appendix C)

I. Standard Contract

Appendix E is a copy of the standard boilerplate contract for the State of Delaware, Delaware of Health and Social Services, Division of Medicaid & Medical Assistance. This boilerplate will be the one used for any contract resulting from this Request for Proposal. If a bidder has an objection to any contract provisions or the RFP and its procurement provisions, objections shall be stated in the Transmittal Letter of the bidder's proposal.

V. BUDGET

Vendor will submit a line item budget, **for each contract year**, describing how funds will be utilized. Budget should include an amount per hour along with an estimation of time per activity. Modifications to the budget after the award must be approved by the Division of Medicaid & Medical Assistance.

Applicants shall also describe any factors that may have an impact on the cost and should suggest a payment schedule contingent upon completion of the various tasks.

VI. GENERAL INSTRUCTIONS FOR SUBMISSION OF PROPOSALS

A. Number of Copies Required

Two (2) original **CDs** (Each Labeled as "Original") and six (6) **CD** copies (Each labeled as "Copy"). In addition, any required confidential financial or audit information relating to the company and not specifically to the proposal may be copied separately to three (3) additional CDs (Each labeled "Corporate Confidential Information"). All CD files shall be in PDF and Microsoft Word formats. Additional file formats (i.e. .xls, .mpp) may be required as requested.

It is the responsibility of the bidder to ensure all submitted CDs are machine readable, virus free and are otherwise error-free. CDs (or their component files) not in this condition may be cause for the vendor to be disqualified from bidding.

Bidders will no longer be required to make hard copies of proposals **with the exception that** one copy of a Cover Letter along with one copy each of Appendices A, B, C, and D must be submitted in hardcopy with original signatures.

The responses to this RFP shall be submitted to:

BRUCE KRUG
Division of Management Services
Delaware Health and Social Services
Main Administration Building, Sullivan Street
Second Floor, Room 257
1901 North duPont Highway
New Castle, DE 19720

B. Closing Date

All responses must be received no later than December 17, 2010 at 12:00 P.M. Later submission will be cause for disqualification.

C. Notification of Acceptance

Notification of the Department's intent to enter into contract negotiations will be made in writing to all bidders.

D. Questions

All questions concerning this Request for Proposal must reference the pertinent RFP section(s) and page number(s). Questions must be in writing and can be either mailed, faxed, or emailed to:

Daniese McMullin-Powell
Social Service Administrator
The Division of Medicaid & Medical Assistance
The Herman Holloway Campus
1901 North Dupont Highway
The Lewis Building
New Castle, DE 19720
Phone: (302) 255-9635
Fax: (302) 255-4413
Daniese.McMullin-Powell@state.de.us

Deadline for submission of all questions is November 12, 2010. Written responses will be faxed or emailed to bidders no later than November 29, 2010. Please include your fax number and/or your email address with your request.

E. Amendments to Proposals

Amendments to proposals will not be accepted after the deadline for proposal submission has passed. The State reserves the right at any time to request clarification and/or further technical information from any or all applicants submitting proposals.

F. Proposals Become State Property

All proposals become the property of the State of Delaware and will not be returned to the bidders. The State will not divulge any information identified as confidential at the time of proposal submission provided the information resides solely on the CD (s) marked confidential.

G. Non-Interference Clause

The awarding of this contract and all aspects of the awarded bidders contractual obligations, projects, literature, books, manuals, and any other relevant materials and work will automatically become property of the State of Delaware. The awarded bidder will not in any manner interfere or retain any information in relationship to the contractual obligations of said contract, at the time of the award or in the future tense.

H. Investigation of Bidder's Qualifications

Delaware Health and Social Services may make such investigation as it deems necessary to determine the ability of the bidder to furnish the required services, and the bidder shall furnish such data as the Department may request for this purpose.

I. RFP and Final Contract

The contents of the RFP will be incorporated into the final contract and will become binding upon the successful bidder. If the bidder is unwilling to comply with any of the requirements, terms, and conditions of the RFP, objections must be clearly stated in the proposal. Objections

will be considered and may be subject to negotiation at the discretion of the State.

J. Proposal and Final Contract

The contents of each proposal will be considered binding on the bidder and subject to subsequent contract confirmation if selected. The contents of the successful proposal will be included by reference in the resulting contract.

All prices, terms, and conditions contained in the proposal will remain fixed and valid for base year(s) of the contract.

K. Cost of Proposal Preparation

All costs for proposal preparation will be borne by the bidder.

L. Proposed Timetable

The Department's proposed schedule for reviewing proposals is outlined as follows:

Activity	***Date***
RFP Advertisement	October 29, 2010
Questions Due	November 12, 2010
Pre-bid Meeting	N/A
Answers to Questions	November 29, 2010
Bid Opening	December 17, 2010
Selection Process Begins	December 17, 2010
Vendor Selection (tentative)	January 14, 2011
Project Begins	March 1, 2011

M. Confidentiality and Debriefing

The Procurement Administrator shall examine the proposal to determine the validity of any written requests for nondisclosure of trade secrets and other proprietary data identified in conjunction with the Attorney General's Office. After award of the contract, all responses, documents, and materials submitted by the offeror pertaining to this RFP will be considered public information and will be made available for inspection, unless otherwise determined by the Director of Purchasing, under the laws of the State of Delaware. All data, documentation, and innovations developed as a result of these contractual services shall become the property of the State of Delaware. Based upon the public nature of these Professional Services (RFP) Proposals an offeror must inform the state in writing, of the exact materials in the offer which CANNOT be made a part of the public record in accordance with Delaware's Freedom of Information Act, Title 29, Chapter 100 of the Delaware Code.

If a bidder wishes to request a debriefing, he must submit a formal letter to the Procurement Administrator, Herman M. Holloway Campus, Delaware Health and Social Services Main Building, 2nd Floor, Room 257, 1901 N. duPont Highway, New Castle, Delaware 19720 within 10 days after receipt of Notice of Award. The letter must specify reasons for the request.

VII. SELECTION PROCESS

All proposals submitted in response to this RFP will be reviewed by an evaluation team composed of representatives of the Division of Medicaid & Medical Assistance, Delaware Health and Social Services, and others as may be deemed appropriate by the Department. Each proposal will be independently reviewed and rated against review criteria. Selection will be based upon the recommendations of the review committee.

A. Proposal Evaluation Criteria

The vendor will be selected through open competition and based on the review of proposals submitted in response to this request for proposals. A technical review panel will review all proposals utilizing the following criteria. A maximum of 100 points is possible.

Category	**Weight**
Meets mandatory RFP provisions	Pass/Fail

Bidder's signature form
Statement of Compliance
Certification Sheet
Office of Minority and Women Business Enterprise
Self-Certification Tracking Form

1.	Qualifications of vendor a) Administrative Oversight b) Past experience in successfully operating quality programs of a similar type and with a similar population c) Quality Assurance Program details d) Available resources	25
2.	Methodology Proposed a) services proposed fit needs as expressed in RFP b) proposed activities follow a logical sequence c) adequacy of workplan & timeline schedules d) builds on existing work of the Division's planning efforts	25
1.	Responses to Scope of Services, Section II. A – I.	20
4.	The degree to which the bidder demonstrates the potential ability to recruit, hire, schedule, and train qualified applicants.	15
5.	Evaluation of the proposed costs as they relate to the proposed service delivery.	15
	Total:	**100**

Upon selection of a vendor, a Division of Medicaid & Medical Assistance representative will enter into negotiations with the bidder to establish a contract.

B. Project Costs and Proposed Scope of Service

The Department reserves the right to award this project to a bidder other than the one with the lowest cost or to decide not to fund this project at all. Cost will be balanced against the score received by each bidder in the rating process. The State of Delaware reserves the right to reject, as technically unqualified, proposals that are unrealistically low if, in the

judgment of the evaluation team, a lack of sufficient budgeted resources would jeopardize project success.

APPENDIX A:

BIDDERS SIGNATURE FORM

DELAWARE HEALTH AND SOCIAL SERVICES
REQUEST FOR PROPOSAL

BIDDERS SIGNATURE FORM

NAME OF BIDDER:_____
SIGNATURE OF AUTHORIZED PERSON:_____
TYPE IN NAME OF AUTHORIZED PERSON:_____
TITLE OF AUTHORIZED PERSON:_____
STREET NAME AND NUMBER:_____
CITY, STATE, & ZIP CODE:_____
CONTACT PERSON:_____
TELEPHONE NUMBER:_____
FAX NUMBER:_____
DATE:_____
BIDDER'S FEDERAL EMPLOYERS IDENTIFICATION NUMBER:_____
DELIVERY DAYS/COMPLETION TIME:_____
F.O.B.:_____
TERMS:_____

THE FOLLOWING MUST BE COMPLETED BY THE VENDOR:

AS CONSIDERATION FOR THE AWARD AND EXECUTION BY THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES OF THIS CONTRACT, THE (COMPANY NAME)_____ HEREBY GRANTS, CONVEYS, SELLS, ASSIGNS, AND TRANSFERS TO THE STATE OF DELAWARE ALL OF ITS RIGHTS, TITLE AND INTEREST IN AND TO ALL KNOWN OR UNKNOWN CAUSES OF ACTION IT PRESENTLY HAS OR MAY NOW HEREAFTER ACQUIRE UNDER THE ANTITRUST LAWS OF THE UNITED STATES AND THE STATE OF DELAWARE, RELATING THE PARTICULAR GOODS OR SERVICES PURCHASED OR ACQUIRED BY THE DELAWARE HEALTH AND SOCIAL SERVICES DEPARTMENT, PURSUANT TO THIS CONTRACT.

APPENDIX B:

CERTIFICATION SHEET

DELAWARE HEALTH AND SOCIAL SERVICES
REQUEST FOR PROPOSAL

CERTIFICATION SHEET

As the official representative for the proposer, I certify on behalf of the agency that:

a. They are a regular dealer in the services being procured.

b. They have the ability to fulfill all requirements specified for development within this RFP.

c. They have independently determined their prices.

d. They are accurately representing their type of business and affiliations.

e. They will secure a Delaware Business License.

f. They have acknowledged that no contingency fees have been paid to obtain award of this contract.

g. The Prices in this offer have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other contractor or with any competitor;

h. Unless otherwise required by Law, the prices which have been quoted in this offer have not been knowingly disclosed by the contractor and prior to the award in the case of a negotiated procurement, directly or indirectly to any other contractor or to any competitor; and

i. No attempt has been made or will be made by the contractor in part to other persons or firm to submit or not to submit an offer for the purpose of restricting competition.

j. They have not employed or retained any company or person (other than a full-time bona fide employee working solely for the contractor) to solicit or

secure this contract, and they have not paid or agreed to pay any company or person (other than a full-time bona fide employee working solely for the contractor) any fee, commission percentage or brokerage fee contingent upon or resulting from the award of this contract.

k. They (check one) operate ___an individual; _____a Partnership ____a non-profit (501 C-3) organization; _____a not-for-profit organization; or _____for profit corporation, incorporated under the laws of the State of _____.

l. The referenced offerer has neither directly or indirectly entered into any agreement, participated in any collusion or otherwise taken any action in restraint of free competitive bidding in connection with this bid submitted this date to Delaware Health and Social Services.

m. The referenced bidder agrees that the signed delivery of this bid represents the bidder's acceptance of the terms and conditions of this invitation to bid including all Specifications and special provisions.

n. They (check one): _____are; _____are not owned or controlled by a parent company. If owned or controlled by a parent company, enter name and address of parent company:

_____
_____
_____
_____

Violations and Penalties:

Each contract entered into by an agency for professional services shall contain a prohibition against contingency fees as follows:

1. The firm offering professional services swears that it has not employed or retained any company or person working primarily for the firm offering professional services, to solicit or secure this agreement by improperly influencing the agency or any of its employees in the professional service procurement process.

2. The firm offering the professional services has not paid or agreed to pay any person, company, corporation, individual or firm other than a bona fide employee working primarily for the firm offering professional services, any fee, commission, percentage, gift, or any other consideration contingent upon or resulting from the award or making of this agreement; and

3. For the violation of this provision, the agency shall have the right to terminate the agreement without liability and at its discretion, to deduct from the contract price, or otherwise recover the full amount of such fee, commission, percentage, gift or consideration.

The following conditions are understood and agreed to:

a. No charges, other than those specified in the cost proposal, are to be levied upon the State as a result of a contract.

b. The State will have exclusive ownership of all products of this contract unless mutually agreed to in writing at the time a binding contract is executed.

Date	Signature & Title of Official Representative
	Type Name of Official Representative

APPENDIX C

STATEMENTS OF COMPLIANCE FORM

DELAWARE HEALTH AND SOCIAL SERVICES
REQUEST FOR PROPOSAL

STATEMENTS OF COMPLIANCE FORM

As the official representative for the contractor, I certify on behalf of the agency that_____ (Company Name) will comply with all Federal and Delaware laws and regulations pertaining to equal employment opportunity and affirmative action. In addition, compliance will be assured in regard to Federal and Delaware laws and regulations relating to confidentiality and individual and family privacy in the collection and reporting of data.

Authorized Signature:_____

Title:_____

Date:_____

APPENDIX D

OFFICE OF MINORITY AND WOMEN BUSINESS ENTERPRISE SELF-CERTIFICATION TRACKING FORM

OFFICE OF MINORITY AND WOMEN BUSINESS ENTERPRISE SELF-CERTIFICATION TRACKING FORM

IF YOUR FIRM WISHES TO BE CONSIDERED FOR ONE OF THE CLASSIFICATIONS LISTED BELOW, THIS PAGE MUST BE SIGNED, NOTARIZED AND RETURNED WITH YOUR PROPOSAL.

COMPANY NAME_____
NAME OF AUTHORIZED REPRESENTATIVE (Please print)

_____
SIGNATURE_____
COMPANY ADDRESS_____
TELEPHONE #_____
FAX #_____
EMAIL ADDRESS_____
FEDERAL EI# _____
STATE OF DE BUSINESS LIC#_____
Note: Signature of the authorized representative must be of an individual who legally may enter his/her organization into a formal contract with the State of Delaware, Delaware Health and Social Services.

Organization Classifications (Please circle)
Women Business Enterprise (WBE) Yes/No
Minority Business Enterprise (MBE) Yes/No
Please check one---Corporation _____
Partnership_____Individual _____

_____
For appropriate certification (WBE), (MBE), please apply to Office of Minority and Women Business Enterprise Phone # (302) 739-4206 L. Jay Burks, Executive Director Fax# (302) 739-1965 Certification #_____ Certifying Agency_____
http://www.state.de.us/omwbe

SWORN TO AND SUBSCRIBED BEFORE ME THIS _____DAY OF _____20_____

NOTARY PUBLIC_____MY COMMISION EXPIRES _____

CITY OF _____COUNTY OF _____STATE OF_____

Definitions

The following definitions are from the State Office of Minority and Women Business Enterprise.

Women Owned Business Enterprise (WBE):
At least 51% is owned by women, or in the case of a publicly owned enterprise, a business enterprise in which at least 51% of the voting stock is owned by women; or any business enterprise that is approved or certified as such for purposes of participation in contracts subject to women-owned business enterprise requirements involving federal programs and federal funds.

Minority Business Enterprise (MBE):
At least 51% is owned by minority group members; or in the case of a publicly owned enterprise, a business enterprise in which at least 51% of the voting stock is owned by minority group members; or any business enterprise that is approved or certified as such for purposes of participation in contracts subjects to minority business enterprises requirements involving federal programs and federal funds.

Corporation:
An artificial legal entity treated as an individual, having rights and liabilities distinct from those of the persons of its members, and vested with the capacity to transact business, within the limits of the powers granted by law to the entity.

Partnership:
An agreement under which two or more persons agree to carry on a business, sharing in the profit or losses, but each liable for losses to the extent of his or her personal assets.

Individual:
Self-explanatory

For certification in one of above, the bidder must contract:
L. Jay Burks
Office of Minority and Women Business Enterprise
(302) 739-4206
Fax (302) 739-5561

APPENDIX E

Contract Boilerplate

DELAWARE HEALTH
AND SOCIAL SERVICES

DMMA CONTRACT # _____
BETWEEN
[DIVISION NAME HERE]
DELAWARE DEPARTMENT OF HEALTH & SOCIAL SERVICES,
AND
[Contractor]
FOR
[TYPE OF SERVICE]

A. Introduction

1. This contract is entered into between the Delaware Department of Health and Social Services (the Department), Division of _____ (Division) and _____ (the Contractor).

2. The Contract shall commence on _____ and terminate on _____ unless specifically extended by an amendment, signed by all parties to the Contract. Time is of the essence. (Effective contract start date is subject to the provisions of Paragraph C. 1. of this Agreement.)

B. Administrative Requirements

1. Contractor recognizes that it is operating as an independent Contractor and that it is liable for any and all losses, penalties, damages, expenses, attorney's fees, judgments, and/or settlements incurred by reason of injury to or death of any and all persons, or injury to any and all property, of any nature, arising out of the Contractor's negligent performance under this Contract, and particularly without limiting the foregoing, caused by, resulting from, or arising out of any act of omission on the part of the Contractor in their negligent performance under this Contract.

2. The Contractor shall maintain such insurance as will protect against claims under Worker's Compensation Act and from any other claims for damages for personal injury, including death, which may arise from operations under this Contract. The Contractor is an independent contractor and is not an employee of the State.

3. During the term of this Contract, the Contractor shall, at its own expense, carry insurance with minimum coverage limits as follows:

a) Comprehensive General Liability $1,000,000

and

	b) Medical/Professional Liability	$1,000,000/ $3,000,000
or	c) Misc. Errors and Omissions	$1,000,000/$3,000,000
or	d) Product Liability	$1,000,000/$3,000,000

All contractors must carry (a) and at least one of (b), (c), or (d), depending on the type of service or product being delivered.

If the contractual service requires the transportation of Departmental clients or staff, the contractor shall, in addition to the above coverage, secure at its own expense the following coverage:

e) Automotive Liability (Bodily Injury)	$100,000/$300,000
f) Automotive Property Damage (to others)	$ 25,000

4. Not withstanding the information contained above, the Contractor shall indemnify and hold harmless the State of Delaware, the Department and the Division from contingent liability to others for damages because of bodily injury, including death, that may result from the Contractor's negligent performance under this Contract, and any other liability for damages for which the Contractor is required to indemnify the State, the Department and the Division under any provision of this Contract.

5. The policies required under Paragraph B. 3. must be written to include Comprehensive General Liability coverage, including Bodily Injury and Property damage insurance to protect against claims arising from the performance of the Contractor and the contractor's subcontractors under this Contract and Medical/Professional Liability coverage when applicable.

6. The Contractor shall provide a Certificate of Insurance as proof that the Contractor has the required insurance. The certificate shall identify the Department and the Division as the "Certificate Holder" and shall be valid for the contract's period of performance as detailed in Paragraph A. 2.

7. The Contractor acknowledges and accepts full responsibility for securing and maintaining all licenses and permits, including the Delaware business license, as applicable and required by law, to engage in business and provide the goods and/or services to be acquired under the terms of this Contract. The Contractor acknowledges and is aware that Delaware law provides for significant penalties associated with the conduct of business without the appropriate license.

8. The Contractor agrees to comply with all State and Federal licensing standards and all other applicable standards as required to provide services under this Contract, to assure the quality of services provided under this Contract. The Contractor shall immediately notify the Department in writing of any change in the status of any accreditations, licenses or certifications in any jurisdiction in which they provide services or conduct business. If this change in status regards the fact that its accreditation, licensure, or certification is suspended, revoked, or otherwise impaired in any jurisdiction, the Contractor understands that such action may be grounds for termination of the Contract.

a) If a contractor is under the regulation of any Department entity and has been assessed Civil Money Penalties (CMPs), or a court has entered a civil judgment against a Contractor or vendor in a case in which DHSS or its agencies was a party, the Contractor or vendor is excluded from other DHSS contractual opportunities or is at risk of contract termination in whole, or in part, until penalties are paid in full or the entity is participating in a corrective action plan approved by the Department.

A corrective action plan must be submitted in writing and must respond to findings of non-compliance with Federal, State, and Department requirements. Corrective action plans must include timeframes for correcting deficiencies and must be approved, in writing, by the Department.

The Contractor will be afforded a thirty (30) day period to cure non-compliance with Section 8(a). If, in the sole judgment of the Department, the Contractor has not made satisfactory progress in curing the infraction(s) within the aforementioned thirty (30) days, then the Department may immediately terminate any and/or all active contracts.

9. Contractor agrees to comply with all the terms, requirements and provisions of the Civil Rights Act of 1964, the Rehabilitation Act of 1973 and any other federal, state, local or any other anti discriminatory act, law, statute, regulation or policy along with all amendments and revision of these laws, in the performance of this Contract and will not discriminate against any applicant or employee or service recipient because of race, creed, religion, age, sex, color, national or ethnic origin, disability or any other unlawful discriminatory basis or criteria.

10. The Contractor agrees to provide to the Divisional Contract Manager, on an annual basis, if requested, information regarding its client population served under this Contract by race, color, national origin or disability.

11. This Contract may be terminated in whole or part:

a) by the Department upon five (5) calendar days written notice for cause or documented unsatisfactory performance,

b) by the Department upon fifteen (15) calendar days written notice of the loss of funding or reduction of funding for the stated Contractor services as described in Appendix B,

c) by either party without cause upon thirty (30) calendar days written notice to the other Party, unless a longer period is specified in Appendix A.

In the event of termination, all finished or unfinished documents, data, studies, surveys, drawings, models, maps, photographs, and reports or other material prepared by Contractor under this contract shall, at the option of the Department, become the property of the Department.

In the event of termination, the Contractor, upon receiving the termination notice, shall immediately cease work and refrain from purchasing contract related items unless otherwise instructed by the Department.

The Contractor shall be entitled to receive reasonable compensation as determined by the Department in its sole discretion for any satisfactory work completed on such documents and other materials that are usable to the Department. Whether such work is satisfactory and usable is determined by the Department in its sole discretion.

Should the Contractor cease conducting business, become insolvent, make a general assignment for the benefit of creditors, suffer or permit the appointment of a receiver for its business or assets, or shall avail itself of, or become subject to any proceeding under the Federal Bankruptcy Act or any other statute of any state relating to insolvency or protection of the rights of creditors, then at the option of the Department, this Contract shall terminate and be of no further force and effect. Contractor shall notify the Department immediately of such events.

12. Any notice required or permitted under this Contract shall be effective upon receipt and may be hand delivered with receipt requested or by registered or certified mail with return receipt requested to the addresses listed below. Either Party may change its address for notices and official formal correspondence upon five (5) days written notice to the other.

To the Division at:

Division name here
address
address
Attn:

To the Contractor at:

_____

_____

_____

13. In the event of amendments to current Federal or State laws which nullify any term(s) or provision(s) of this Contract, the remainder of the Contract will remain unaffected.

14. This Contract shall not be altered, changed, modified or amended except by written consent of all Parties to the Contract.

15. The Contractor shall not enter into any subcontract for any portion of the services covered by this Contract without obtaining prior written approval of the Department. Any such subcontract shall be subject to all the conditions and provisions of this Contract. The approval requirements of this paragraph do not extend to the purchase of articles, supplies, equipment, rentals, leases and other day-to-day operational expenses in support of staff or facilities providing the services covered by this Contract.

16. This entire Contract between the Contractor and the Department is composed of these several pages and the attached Appendix ___.

17. This Contract shall be interpreted and any disputes resolved according to the Laws of the State of Delaware. Except as may be otherwise provided in this contract, all claims, counterclaims, disputes and other matters in question between the Department and Contractor arising out of or relating to this Contract or the breach thereof will be decided by arbitration if the parties hereto mutually agree, or in a court of competent jurisdiction within the State of Delaware.

18. In the event Contractor is successful in an action under the antitrust laws of the United States and/or the State of Delaware against a vendor, supplier, subcontractor, or other party who provides particular goods or services to the Contractor that impact the budget for this Contract, Contractor agrees to reimburse the State of Delaware, Department of Health and Social Services for the pro-rata portion of the damages awarded that are attributable to the goods or services used by the Contractor to fulfill the requirements of this Contract. In the event Contractor refuses or neglects after reasonable written notice by the Department to bring such antitrust action, Contractor shall be deemed to have assigned such action to the Department.

19. Contractor covenants that it presently has no interest and shall not acquire any interests, direct or indirect, that would conflict in any manner or degree with the performance of this Contract. Contractor further covenants that in the performance of this contract, it shall not employ any person having such interest.

20. Contractor covenants that it has not employed or retained any company or person who is working primarily for the Contractor, to solicit or secure this agreement, by improperly

influencing the Department or any of its employees in any professional procurement process; and, the Contractor has not paid or agreed to pay any person, company, corporation, individual or firm, other than a bona fide employee working primarily for the Contractor, any fee, commission, percentage, gift or any other consideration contingent upon or resulting from the award or making of this agreement. For the violation of this provision, the Department shall have the right to terminate the agreement without liability and, at its discretion, to deduct from the contract price, or otherwise recover, the full amount of such fee, commission, percentage, gift or consideration.

21. The Department shall have the unrestricted authority to publish, disclose, distribute and otherwise use, in whole or in part, any reports, data, or other materials prepared under this Contract. Contractor shall have no right to copyright any material produced in whole or in part under this Contract. Upon the request of the Department, the Contractor shall execute additional documents as are required to assure the transfer of such copyrights to the Department.

If the use of any services or deliverables is prohibited by court action based on a U.S. patent or copyright infringement claim, Contractor shall, at its own expense, buy for the Department the right to continue using the services or deliverables or modify or replace the product with no material loss in use, at the option of the Department.

22. Contractor agrees that no information obtained pursuant to this Contract may be released in any form except in compliance with applicable laws and policies on the confidentiality of information and except as necessary for the proper discharge of the Contractor's obligations under this Contract.

23. Waiver of any default shall not be deemed to be a waiver of any subsequent default. Waiver or breach of any provision of this Contract shall not be deemed to be a waiver of any other or subsequent breach and shall not be construed to be a modification of the terms of the Contract unless stated to be such in writing, signed by authorized representatives of all parties and attached to the original Contract.

24. If the amount of this contract listed in Paragraph C2 is over $25,000, the Contractor, by their signature in Section E, is representing that the Firm and/or its Principals, along with its subcontractors and assignees under this agreement, are not currently subject to either suspension or debarment from Procurement and Non-Procurement activities by the Federal Government.

C. Financial Requirements

1. The rights and obligations of each Party to this Contract are not effective and no Party is bound by the terms of this contract unless, and until, a validly executed Purchase Order is approved by the Secretary of Finance and received by Contractor, *if required by the State of Delaware Budget and Accounting Manual,* and all policies and procedures of the Department of Finance have been met. The obligations of the Department under this

Contract are expressly limited to the amount of any approved Purchase Order. The State will not be liable for expenditures made or services delivered prior to Contractor's receipt of the Purchase Order.

2. Total payments under this Contract shall not exceed $ _____ in accordance with the budget presented in Appendix ___. Payment will be made upon receipt of an itemized invoice from the Contractor in accordance with the payment schedule, if any**.** The contractor or vendor must accept full payment by procurement (credit) card and or conventional check and/or other electronic means at the State's option, without imposing any additional fees, costs or conditions. Contractor is responsible for costs incurred in excess of the total cost of this Contract and the Department is not responsible for such costs.

3. The Contractor is solely responsible for the payment of all amounts due to all subcontractors and suppliers of goods, materials or services which may have been acquired by or provided to the Contractor in the performance of this contract. The Department is not responsible for the payment of such subcontractors or suppliers.

4. The Contractor shall not assign the Contract or any portion thereof without prior written approval of the Department and subject to such conditions and revisions as the Department may deem necessary. No such approval by the Department of any assignment shall be deemed to provide for the incurrence of any obligations of the Department in addition to the total agreed upon price of the Contract.

5. Contractor shall maintain books, records, documents and other evidence directly pertinent to performance under this Contract in accordance with generally accepted accounting principles and practices. Contractor shall also maintain the financial information and data used by Contractor in the preparation of support of its bid or proposal. Contractor shall retain this information for a period of five (5) years from the date services were rendered by the Contractor. Records involving matters in litigation shall be retained for one (1) year following the termination of such litigation. The Department shall have access to such books, records, documents, and other evidence for the purpose of inspection, auditing, and copying during normal business hours of the Contractor after giving reasonable notice. Contractor will provide facilities for such access and inspection.

6. The Contractor agrees that any submission by or on behalf of the Contractor of any claim for payment by the Department shall constitute certification by the Contractor that the services or items for which payment is claimed were actually rendered by the Contractor or its agents, and that all information submitted in support of the claims is true, accurate, and complete.

7. The cost of any Contract audit disallowances resulting from the examination of the Contractor's financial records will be borne by the Contractor. Reimbursement to the Department for disallowances shall be drawn from the Contractor's own resources and not charged to Contract costs or cost pools indirectly charging Contract costs.

8. When the Department desires any addition or deletion to the deliverables or a change in the services to be provided under this Contract, it shall so notify the Contractor. The Department will develop a Contract Amendment authorizing said change. The Amendment shall state whether the change shall cause an alteration in the price or time required by the Contractor for any aspect of its performance under the Contract. Pricing of changes shall be consistent with those prices or costs established within this Contract. Such amendment shall not be effective until executed by all Parties pursuant to Paragraph B.14.

D. Miscellaneous Requirements

1. *If applicable*, the Contractor agrees to adhere to the requirements of DHSS Policy Memorandum # 46, (PM # 46, effective 3/11/05), and divisional procedures regarding the reporting and investigation of suspected abuse, neglect, mistreatment, misappropriation of property and significant injury of residents/clients receiving services, including providing testimony at any administrative proceedings arising from such investigations. The policy and procedures are included as Appendix _____ to this Contract. It is understood that adherence to this policy includes the development of appropriate procedures to implement the policy and ensuring staff receive appropriate training on the policy requirements. The Contractor's procedures must include the position(s) responsible for the PM46 process in the provider agency. Documentation of staff training on PM46 must be maintained by the Contractor.

2. The Contractor, including its parent company and its subsidiaries, and any subcontractor, including its parent company and subsidiaries, agree to comply with the provisions of 29 Del. Code, Chapter 58: "Laws Regulating the Conduct of Officers and Employees of the State," and in particular with Section 5805 (d): "Post Employment Restrictions."

3. *When required by Law*, Contractor shall conduct child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del. Code Section 708; and 11 Del. Code, Sections 8563 and 8564. Contractor shall not employ individuals with adverse registry findings in the performance of this contract.

4. *If applicable*, the Contractor agrees to adhere to the requirements of DHSS Policy Memorandum # 40, and divisional procedures regarding conducting criminal background checks and handling adverse findings of the criminal background checks. This policy and procedure are included as Appendix _____ to this Contract. It is understood that adherence to this policy includes the development of appropriate procedures to implement the policy and ensuring staff receive appropriate training on the policy requirements. The Contractor's procedures must include the title of the position(s) responsible for the PM40 process in the contractor's agency.

5. *If applicable*, the Contractor agrees to adhere to the requirements of DHSS Policy Memorandum # 36 (PM #36, effective 9/24/2008), and divisional procedures regarding minimal requirements of contractors who are engaging in a contractual agreement to develop community based residential arrangements for those individuals served by

Divisions within DHSS. This policy and procedure are included as Appendix ____ to this Contract. It is understood that adherence to this policy includes individuals/entities that enter into a contractual arrangement (*contractors*) with the DHSS/Division to develop a community based residential home(s) and apartment(s). Contractors shall be responsible for their subcontractors' adherence with this policy and related protocol(s) established by the applicable Division.

6. All Department campuses are tobacco-free. Contractors, their employees and sub-contractors are prohibited from using any tobacco products while on Department property. This prohibition extends to personal vehicles parked in Department parking lots.

E. Authorized Signatures:

For the Contractor:

_____
Signature

_____
Name (please print)

_____
Title

_____
Date

For the Department:

_____
Rita M. Landgraf
Secretary

_____
Date

For the Division:

_____
[**Authorized Division Name Here**]

_____
Date

APPENDIX A

DIVISION OF MEDICAID & MEDICAL ASSISTANCE REQUIREMENTS

1. Funds received and expended under the contract must be recorded so as to permit the Division to audit and account for all contract expenditures in conformity with the terms, conditions, and provisions of this contract, and with all pertinent federal and state laws and regulations. The Division retains the right to approve this accounting system.

2. The Contractor shall recognize that no extra contractual services are approved unless specifically authorized in writing by the Division. Further, the Contractor shall recognize that any and all services performed outside the scope covered by this Contract and attached budgets will be deemed by the Division to be gratuitous and not subject to any financial reimbursement.

3. All products are expected to be free of misspellings and typos, as well as punctuation, grammatical and design errors. Acronyms should be avoided; when used, they should be spelled out on first reference with the acronym in parentheses after that reference. For example, 'Division of Social Services (DSS)' on first reference.

4. No part of any funds under this contract shall be used to pay the salary or expenses of any contractor or agent acting for the contractor, to engage in any activity (lobbying) designed to influence legislation or appropriations pending before the State Legislature and/or Congress.

5. The contractor agrees that, if defunding occurs, all equipment purchased with Division funds for $1,000.00 or more and a useful life expectancy of one (1) year, will be returned to the Division within thirty (30) days.

6. Contractors receiving Federal funds must comply with all the requirements of the Federal Office of Management and Budget (OMB) Circular A-133, Audits of State, Local Governments, and Non-profit Organizations.

APPENDIX F

SERVICE AND BUDGET DESCRIPTION

1. Contractor: _____

   Address: _____

   _____

   Phone _____

   E.I. No.: _____

2. Division: _____

3. Service:] _____

   _____

   _____

4. Total Payment shall not exceed _____.

5. Payment(s) will be made upon presentation of invoice(s) with supporting documentation that verifies the completed, acceptable deliverable(s). Invoice must contain period of service, Vendor Invoice Number, Vendor EI Number, Contract Number, Division Purchase Order Number and itemized description of the services provided to coincide with the contract deliverables. (See also Paragraph C.2. of the contract)

6. Source of Contract Funding:

   _____ Federal Funds (CFDA#_____)
   _____ State Funds
   _____ Other Funds
   _____ Combination of Funds

DESCRIPTION OF ALLOWABLE COSTS

DESCRIPTION OF LINE ITEMS

Salaries and Wages	Project Directors, Supervisors, Site Managers, Healthcare workers, Nutritionists, Clerks, Accountants, Bookkeepers, Janitors, Drivers, Case Managers, Outreach Workers, Secretaries, Training Instructors, Laborers, Executive Directors, Dietitians, Activity Coordinators, etc.
Fringe Benefits	Proportionate fringe benefits for above labor including Social Security, unemployment compensation, life insurance, worker's compensation, health insurance, pension, etc. paid by the agency.
Travel/Training	Include any staff training costs. Mileage reimbursement shall be a maximum of $.41 per mile. Training may include subscriptions and association dues.
Contractual Services	Rent, utilities, repairs (building, vehicle, equipment, etc.), telephone, advertising, printing, transportation insurance, vehicle, communication, consultants, tax preparation, storage, audit costs, etc.
Supplies	Health supplies, program supplies, office supplies, janitorial, building (not sub-contracts), educational, medical, any type of meals purchased, etc.
Other/Equipment Any items or lot costing $1000.00 and a useful life of one (1) year or more.	The only equipment, which will be considered for *FY '06*, is computer software for existing equipment. Please attach detailed justification. No other equipment is permitted. A separate request with written justification will be considered.

Budget Worksheets and Instructions

Line Item/Description	Amount
Salary/Wages (list each position title)	
Sub-total: Salaries and Wages	
Fringe Benefits (proportionate fringe benefits for above labor including Social Security, unemployment compensation, life insurance, worker's compensations, health insurance, pension, etc. paid by the agency)	
Sub-total: Fringe Benefits	
Travel /Training (include any program required staff training costs. Mileage reimbursement shall be a maximum of $.41 per mile. Training may include subscriptions and association dues.)	
Sub-total: Travel/Training	

Budget Worksheets and Instructions (Continued)

Line Item/Description	Amount
Contractual Services (Rent, utilities, repairs (building, vehicle, equipment, etc.), telephone, advertising, printing, transportation insurance, vehicle, communication, consultants, tax preparation, storage, audit costs, etc.)	
Sub-total: Contractual Services	
Supplies (Health supplies, program supplies, office supplies, janitorial, building (not sub-contracts), educational, medical, any type of meals purchased, etc	
Sub-total: Supplies	
Other Equipment (Any items or lot costing $1000.00 and a useful life of one (1) year or more.)	
Sub-total: Other Equipment	
TOTAL ALLOWABLE COSTS	
REQUESTED UNIT COST PER ASSESSMENT	

APPENDIX G

DHSS HOME & COMMUNITY BASED WAIVER & NURSING FACILITY PROGRAM

ASSESSEMENT TOOL

Delaware Department of Health and Social Services
Long Term Care programs
Divisions of Services for Aging and Adults with Physical Disabilities (DSAAPD)
Division of Medicaid and Medical Assistance (DMMA)

Cover Sheet

A. CLIENT:

Name:_____DOB:_____ SSN:_____

Current Location: _____

B. Assessment Type: ☐ Nursing home- Medicaid ☐ HCBS ☐ AH waiver ☐ State facility LOC ☐ Hospice ☐ Foster care LOC ☐ PASARR only ☐ PASARR private pay ☐ Superskilled payment ☐ other _____

C. Person requesting this assessment: ☐ Hospital ☐ NF ☐ client ☐ Family ☐ DSAAPD/APS ☐ DSAAPD/CSP ☐ DSS/LTC ☐ DSS/FACMU or SSI ☐ DSS/other unit ☐ Other agency ☐ Assessor

D. Assessing division and type of assessment:

☐ DSAAPD
- ☐ APS
- ☐ APS update
- ☐ CSP intake
- ☐ CSP update
- ☐ CSP redetermination

☐ DSS
- ☐ PAS intake
- ☐ PAS update
- ☐ PAS redetermination
- ☐ Inst. intake
- ☐ Inst. update
- ☐ Inst. redetermination

E. Assessment sections to be/were completed by:

Case Manager:
- ☐ 1. General info
- ☐ 2. Physical Health
- ☐ 3. ADLs
- ☐ 4. Environment
- ☐ 5. Activities/Social environ.
- ☐ 6. I ADLs
- ☐ 7. Social history
- ☐ 8. Mental Health
- ☐ 9. Financial resources
- ☐ 10. Informal supports
- ☐ 11. Formal supports
- ☐ 12. Conclusion

Nurse:
- ☐ 1. General info
- ☐ 2. Physical Health
- ☐ 3. ADLs
- ☐ 4. Environment
- ☐ 5. Activities/Social environ.
- ☐ 6. I ADLs
- ☐ 7. Social history
- ☐ 8. Mental Health
- ☐ 9. Financial
- ☐ 10. Informal supports
- ☐ 11. Formal supports
- ☐ 12. Conclusion

F. Supporting information to be obtained by:

Case Manager:	**Nurse:**
☐ Auth. to obtain/release info form	☐ Auth. to obtain/release info form
☐ MAP25 / medical report	☐ MAP25 / medical report
☐ HCBS1 / Awareness form	☐ HCBS1 / Awareness form
☐ MI release form	☐ MI release form
☐ MR release form	☐ MR release form
☐ other _____	☐ other _____

1. PHYSICAL HEALTH EVALUATION For: [redacted]

A. CLIENT INTERVIEW: Date: _____

1. Client interviewed at - (Check one)

☐ residence ☐ hospital ☐ nursing home ☐ other care setting

Interview waived due to: ☐ client out of state ☐ telephone update ☐ other _____

Information also obtained from: ☐ relative ☐ paid caregiver ☐ medical records ☐ other ☐ none

Names of those present:

2. Client's primary language is - (Check one) ☐ English ☐ Polish ☐ Italian ☐ Spanish ☐ German

☐ Greek ☐ Japanese/Korean/Vietnamese ☐ other_____

☐ interpreter used: Name:_____ phone:_____

3. Client's speaking ability - (Check one)

☐ speaks clearly with others of same language ☐ some difficulty but usually gets message across

☐ unable to speak clearly or at all

☐ uses alternate method of communication: ☐ sign language ☐ comm device or board

☐ other_____

B. SELF-RATED HEALTH:

RATED BY: ☐ Relative ☐ Paid Caregiver ☐ Other ☐ Not Able ☐ Not Rated

(If not able or not rated do not complete 1-4 below)

1. How would you rate your overall health at the present time? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

2. Compared to a year ago, would you say your health is? ☐ Better ☐ Same ☐ Worse

3. Does your health limit your daily activities? ☐ Not at All ☐ At Little/Some ☐ A Great Deal ☐ Not Sure

4. What is your biggest problem affecting your life and health? (In Client's Own Words)

_____

5. What condition(s) limit you the most in your ability to care for yourself?

_____

_____

C. PAST HEALTH HISTORY: ☐ unable to obtain info

1. Have you had any hospitalizations? ☐ none ☐ past 3 months ☐ past year ☐ unsure ☐ info not available

2. Do you have any allergies/intolerances?: ☐ no ☐ meds ☐ food ☐ environmental ☐ info not avail.

List all: _____

3. Have you had the following immunizations? (check all that apply) ☐ info not available
☐ DT (diptheria/tetanus) ☐ Pneumovax (year_____) ☐ Heptavax ☐ Flu shot (year_____)
☐ PPD (year _____) ☐ Tine (year _____) ☐ other_____

4. Indicate most recent primary physician and/or specialist visit (include name, date, reason)

_____

5. List names (address and phone # if known) of all physicians that have treated applicant:

_____

_____

_____

6. Indicate past medical history and Surgical History:

_____

_____

_____

D. CURRENT HEALTH STATUS: ☐ not assessed

Primary diagnosis/presenting problem category: ☐ Mental Illness ☐ Intellectual Disability

☐ Developmental Disability

☐ Alcohol/Drug Abuse ☐ Physical Disabilities ☐ none of the above

1. Primary diagnosis/presenting problem specifically:_____

2. Secondary diagnosis/presenting problem:_____

3. Tertiary diagnoses/other medical problems: _____

Diagnoses confirmed by medical report from attending physician? ☐ Yes ☐ No

4. Current medications: _____

_____

_____

_____

_____

_____

_____

5. Current treatments:_____

_____

_____

_____

6. Diagnostic tests (indicate pertinent lab, xray, test results)_____

_____

_____

_____

_____

_____

7. Medical problems appear to be: ☐ **acute:** ☐ improving ☐ stable ☐ deteriorating
☐ **chronic:** ☐ improving ☐ stable ☐ deteriorating

8. Additional Comments:_____

_____

_____

_____

_____

_____

_____

_____

E. HEALTH SYSTEMS REVIEW: ☐ THIS SECTION NOT ASSESSED

1. Eyes and Ears

a. VISION: ☐ not assessed ☐ no correction ☐ wears corrective lens

b. Left eye vision:
- ☐ adequate
- ☐ inadequate
- ☐ legally blind
- ☐ prosthesis

c. Right eye vision:
- ☐ adequate
- ☐ inadequate
- ☐ legally blind
- ☐ prosthesis

EYES: ☐ not assessed

d. Left eye:
- ☐ no complaints
- ☐ pain
- ☐ discharge
- ☐ cataract present
- ☐ cataract removal
- ☐ lens implant
- ☐ other surgery
- ☐ glaucoma
- ☐ blurring
- ☐ double vision
- ☐ retinopathy
- ☐ night blindness
- ☐ light sensitivity
- ☐ other _____

e. Right eye:
- ☐ no complaints
- ☐ pain
- ☐ discharge
- ☐ cataract present
- ☐ cataract removal
- ☐ lens implant
- ☐ other surgery
- ☐ glaucoma
- ☐ blurring
- ☐ double vision
- ☐ retinopathy
- ☐ night blindness
- ☐ light sensitivity
- ☐ other _____

EARS: ☐ not assessed

f. Left ear:
- ☐ no complaints
- ☐ wears aid
- ☐ hard of hearing
- ☐ deaf
- ☐ tinnitis (ringing)
- ☐ vertigo (dizziness)
- ☐ pain
- ☐ unknown
- ☐ other_____

g. Right ear:
- ☐ no complaints
- ☐ wears aid
- ☐ hard of hearing
- ☐ deaf
- ☐ tinnitus (ringing)
- ☐ vertigo (dizziness)
- ☐ pain
- ☐ unknown
- ☐ other _____

☐ unknown ☐ unknown

h. Last eye exam: ☐ < 6 mos ago ☐ 6 mos- 2 yrs ☐ > 2 yrs ☐ recommended ☐ unknown

i. Last hearing exam: ☐ < 6 mos ago ☐ 6 mos- 2yrs ☐ > 2 yrs ☐ recommended ☐ unknown

2. NOSE/ THROAT/ MOUTH: ☐ not assessed

a. Nose: ☐ no complaints/symptoms ☐ frequent colds ☐ sinus infections ☐ stuffiness/allergies ☐ nose bleeds ☐ septal deviation ☐ loss of smell ☐ other _____

b. Throat/Mouth: ☐ no complaints/symptoms ☐ sore throats ☐ difficult swallowing ☐ problems chewing ☐ loss of taste
☐ mouth ulcers ☐ halitosis ☐ other _____

c. Oral hygiene: ☐ adequate ☐ inadequate

d. Dentition: ☐ has natural teeth ☐ bridge/partial denture ☐ upper denture ☐ lower denture ☐ gum disease ☐ edentulous (none) ☐ other _____

e. Last dental exam: ☐ < 6 mos ago ☐ 6 mos- 2 yrs ☐ > 2 yrs ☐ recommended

3. NECK: ☐ not assessed

☐ no complaints/symptoms ☐ stiffness ☐ swelling ☐ neck vein distention (swelling) ☐ neck pain ☐ arthritis ☐ deformity ☐ other _____

4. NEUROLOGICAL: ☐ not assessed

a. Level of consciousness: ☐ alert ☐somnolent/sleepy ☐ lethargic ☐stuporous ☐ non-responsive ☐ other _____

b. Neuro system:

☐ no complaints/symptoms ☐ frequent headaches ☐ convulsions/ grand mal seizures ☐ petit mal seizures ☐ loss of balance ☐ fine motor impairment ☐ gross motor impairment ☐ tingling hands ☐ tingling feet ☐ fainting ☐ dizziness ☐ poor coordination ☐ hx of CVA ☐ hx of Parkinson's ☐ hx of dementia ☐ neuro workup done _____ ☐ other _____

_____

5. **MUSCULOSKELETAL:** ☐ not assessed

a. LEFT arm:
☐ no complaints
☐ paresis (numbness)
☐ plegia (paralysis)
☐ contracture
☐ amputation
☐ prosthesis
☐ Range of Motion:
☐ functional
☐ non-functional
☐ other _____

b. RIGHT arm:
☐ no complaints
☐ paresis (numbness)
☐ plegia (paralysis)
☐ contracture
☐ amputation
☐ prosthesis
☐ Range of Motion:
☐ functional
☐ non-functional
☐ other _____

c. LEFT leg:
☐ no complaints
☐ paresis (numbness)
☐ plegia (paralysis)
☐ contracture
☐ amputation
☐ prosthesis
☐ Range of Motion:
☐ functional
☐ non-functional
☐ other _____

d. RIGHT leg:
☐ no complaints
☐ paresis (numbness)
☐ plegia (paralysis)
☐ contracture
☐ amputation
☐ prosthesis
☐ Range of Motion:
☐ functional
☐ non-functional
☐ other _____

e. Gait:

☐ no assistive devices ☐ non ambulatory ☐ unsteady gait
☐ uses assistive devices: ☐ manual wheelchair ☐ electric wheelchair ☐ walker ☐ cane ☐ crutches
☐ braces ☐ other _____

f. M/S system:

☐ no complaints/symptoms ☐ osteoarthritis/DJD ☐ rheumatoid arthritis ☐ compression fracture
☐ swelling of joints ☐ gout ☐ joint pain ☐ back pain ☐ back problems ☐ leg cramps ☐ slumping posture
☐ early morning stiffness ☐ trembling of hands ☐ tremors ☐ hx of muscle disease (MS, MD, polio)

☐ kyphosis ☐ lordosis ☐ scoliosis ☐ spinal compression

Abnormal involuntary movements of: ☐ head ☐ mouth/tongue ☐ hands ☐ feet
Podiatric problems: ☐ bunions ☐ ingrown nails ☐ athlete's feet ☐ treated by podiatrist ☐ Ram's horn nails

☐ other _____

6. GASTROINTESTINAL: ☐ not assessed

a. Height:_____ **b. Weight:**_____
c. Body mass: ☐ healthy ☐ malnourished ☐ obese ☐ thin ☐ cachectic
d. Diet: ☐ Regular
☐ Restricted: ☐ ADA ☐ low Na ☐ renal ☐ low chol ☐ low fat ☐ low K+ ☐ high K+
☐ low protein ☐ mech. soft ☐ bland ☐ no conc. sweets ☐ clear liq ☐ full liq
☐ as tolerated ☐ other _____
☐ Non-oral diet: ☐ TPN ☐ PEG tube ☐ NG tube ☐ tube fed plus oral supplements
e. GI system:
☐ no complaints/symptoms ☐ heartburn ☐ abd. cramps ☐ abd. pain ☐ nausea ☐ vomiting ☐ belching
☐ hiatal hernia ☐ hemorrhoids ☐ polyps ☐ rectal prolapse ☐ bowel irregularity ☐ frequent constipation
☐ frequent diarrhea ☐ colitis ☐ colostomy ☐ uses laxatives/enemas ☐ Hemocult done within past yr
☐ > 10 lb weight loss in past yr ☐ > 10 lb gain in past year
☐ bowel incontinence (frequency:_____) ☐ other _____

7. ENDOCRINE: ☐ not assessed

☐ no complaints/symptoms ☐ NIDDM ☐ IDDM ☐ self administers insulin ☐ brittle diabetic ☐ sliding scale coverage
☐ checks own blood sugars ☐ excessive hunger/thirst/urination ☐ hx of hypoglycemia ☐ hypothyroid ☐ hyperthyroid
☐ heat/cold intolerance ☐ liver disease ☐ jaundice ☐ chronic/dormant hepatitis ☐ other_____

8. CIRCULATORY: ☐ not assessed

a. B/P:_____ b. Pulse:_____ c. heart rate and rhythm:_____
☐ no complaints/symptoms ☐ cold hands ☐ cold feet ☐ swelling of feet ☐ swelling of hands
☐ shortness of breath ☐ neck veins distended ☐ chest pain ☐ palpitations (heart racing) ☐ hypertension
☐ hx of MI/heart attack ☐ hx of CHF hx of CVA ☐ has pacemaker ☐ hx of bypass surgery
☐ discoloration/blueness of hands/feet ☐ varicose veins ☐ hardening of arteries ☐ general poor circ. ☐ hx of blood clots
☐anticoagulent therapy ☐ other_____

9. **RESPIRATORY:** ☐ not assessed

☐ no complaints/symptoms ☐ wheezing ☐ asthma ☐ short of breath continuously ☐ short of breath on exertion
☐ cyanosis/blueness of lips or nailbeds ☐ breathes via stoma ☐ has temporary trach
☐ has permanent trach ☐ suctioned (describe in comments) ☐ dry cough ☐ productive cough ☐ hx of TB
☐ hx of bronchitis ☐ pneumonia ☐ COPD ☐ emphysema ☐ does not smoke ☐ smokes < 1 ppd
☐ smokes > 1 ppd ☐ other:_____
☐Uses O_2: ☐ continuous ☐ intermittent ☐ on mechanical ventilator (see comments)

10. SKIN: ☐ not assessed

☐ no complaints/symptoms ☐ dryness ☐ poor turgor ☐ rashes ☐ lesions ☐ burns ☐ sores that won't heal
☐ moles that have changed color/size ☐ surgical wound ☐ decubiti ☐ lumps ☐ unexplained bruises
☐ fragile/ tears easily ☐ purpura (purple areas) ☐ psoriasis ☐ dermatitis ☐ excoriated areas ☐ hair loss
☐ non-age related baldness ☐ finger nail fungus ☐ toenail fungus ☐ other:_____

11. GENITOURINARY: ☐ not assessed

☐ no complaints/symptoms ☐ stress incontinence ☐ urge incontinence ☐ inct. at night ☐ inct. always ☐ frequency
☐ urine retention ☐ infection ☐ kidney disease ☐ intermittent caths ☐ indwelling cath ☐ urostomy
☐ peritoneal dialysis ☐ hemodialysis ☐ bladder prolapse ☐ uterine prolapse ☐ GYN disease
☐ premenopausal ☐ post menopausal ☐ prostate enlargement ☐ other:_____

12. INFECTIOUS DISEASES and INFECTIOUS PROCESSES:

☐ active TB ☐ HIV+ ☐ AIDS defined ☐ active hepatitis B ☐ Hepatitis C ☐ shingles ☐ herpes simplex
☐ MRSA ☐ VRE ☐ septicemia ☐ wound infection ☐ respiratory infection
☐ other _____

COMMENTS SECTION - PHYSICAL HEALTH:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Risk Determination PHYSICAL HEALTH:

Based on this physical health assessment, the client's overall health puts the client at:

☐ **(1) No risk** ☐ **(2) Low risk** ☐ **(3) Moderate risk** ☐ **(4) High risk**

to be able to manage his or her own health and medical care.

2. ADL's

☐ **Module Not assessed** ☐ **Self Reported** ☐ **Caregiver Reported** ☐ **Observed**

Bathing:	**Hygiene:**	**Dressing:**	**Eating:**
☐ bathes self	☐ self care	☐ dresses self	☐ prepares own meals
☐ bathes at sink	☐ assist with shaving	☐ reminded to get dressed	☐ home delivered meals
☐ bathed in bed	☐ assist with shampoo	☐ assist with fasteners, shoes, zippers, etc	☐ feeds self
☐ assisted with tub bath only	☐ assist with oral care		☐ help with containers, cutting
☐ only tub bathes	☐ assist with hand nails	☐ frequent changes of clothes	☐ would not eat unless remind
☐ shower with assist	☐ assist with toe nails	☐ puts on own braces/prostheses	☐ must be observed
☐ uses shower chair	☐ keeps self neat and clean	☐ assist with braces/prostheses	☐ fed each meal by hand
☐ other devices	☐ needs reminders	☐ bed clothes only	☐ tube fed
☐ needs assist w/ feet, back	☐ total care	☐ assist to dress for outside weather	☐ nothing by mouth
☐ set up water, supplies			☐ both oral and by tube
☐ unwilling to bathe self		☐ total care	☐ aspiration risk
SCORING:	**SCORING:**	**SCORING:**	**SCORING:**
☐ independent	☐ independent	☐ independent	☐ independent
☐ supervised/ min assist	☐ supervised/ min assist	☐ supervised/ min assist	☐ supervised/ min assist
☐ moderate assist	☐ moderate assist	☐ moderate assist	☐ moderate assist
☐ max assist/ total care	☐ max assist/ total care	☐ max assist/ total care	☐ max assist/ total care

Mobility:	**Transferring:**	**Toileting:**
☐ walks and climbs stairs	☐ transfers self	☐ uses toilet
☐ uses cane/crutches	☐ uses transfer board by self	☐ uses bedpan
☐ walker	☐ helped with commode	☐ uses urinal
☐ standard wheelchair	☐ 1 person pivot assist	☐ rarely incontinent urine
☐ electric wheelchairr	☐ 1 person total lift	☐ occassional incontinent urine
☐ wheels self independently	☐ 2 person total lift	☐ always incontinent urine
☐ walks short distance- wheel chair for longer distance	☐ mechanical (Hoyer) lift	☐ rarely incontinent bowel
		☐ occ. incontinent bowel
☐ confined to bed		☐ always incontinent bowel
☐ turns self in bed		☐ has ostomy
☐ assist with turn/positioning		☐ has colostomy
SCORING:	**SCORING:**	**SCORING:**
☐ independent	☐ independent	☐ independent
☐ supervised/ min assist	☐ supervised/ min assist	☐ supervised/ min assist
☐ moderate assist	☐ moderate assist	☐ moderate assist
☐ max assist/ total care	☐ max assist/ total care	☐ max assist/ total care

COMMENTS SECTION - ADL's: include any comments that would assist future caregivers

_____

_____

Risk Determination ADL's:

Based on this assessment of the client's ability to perform ADLs, there is:

☐ **(1) No risk** ☐ **(2) Low risk** ☐ **(3) Moderate risk** ☐ **(4) High risk**

that the client cannot care for him or herself.

3. ENVIRONMENT

☐ **This Module Not Assessed**

A. DWELLING TYPE: (Check one) or ☐ not assessed ☐ unable to obtain info

☐ Homeless (not shelter)	☐ Subsidized housing	☐ Group home
☐ Emergency housing	☐ Rental housing	☐ Adult foster care
☐ Institution, private	☐ House (owned outright)	☐ Home sharing (agency)
☐ Nursing Home, State	☐ House (mortgage balance)	☐ Home sharing (informal)
☐ Nursing Home, private	☐ Mobile home	☐ Congregate facility
☐ Institution, State (non NH)	☐ Personal care facility (Assisted Living)	☐ Other (See Comments)

B. CURRENT LIVING ARRANGEMENT: (Check one)

☐ Alone	☐ With Child	☐ With Non-Relative
☐ With Spouse	☐ With Grandchild	☐ Unknown
☐ With Parent	☐ With Other Relative	

C. ENVIRONMENT: Select the appropriate value in each area: **or** ☐ **not assessed**

	Good	*Adequate*	*Inadequate*	*Dangerous*	
Structure	⓪	①	②	③	
Furniture	⓪	①	②	③	
Electricity	⓪	①	②	③	
Plumbing	⓪	①	②	③	
Water (hot/cold)	⓪	①	②	③	
Heat/cooling	⓪	①	②	③	
Laundry Facilities	⓪	①	②	③	
Stove	⓪	①	②	③	
Refrigerator	⓪	①	②	③	
Telephone	⓪	①	②	③	
Sanitation	⓪	①	②	③	
Accessibility	⓪	①	②	③	
Pet control	⓪	①	②	③	
Pest/rodent control	⓪	①	②	③	
Fire safety	⓪	①	②	③	
Neighborhood safety	⓪	①	②	③	
Shopping accessibility	⓪	①	②	③	
Transportation accessibility	⓪	①	②	③	**TOTAL all values**

D. COMMENTS SECTION - PHYSICAL ENVIRONMENT:

_____

_____

Risk Determination PHYSICAL ENVIRONMENT:

Based on this assessment of the client's physical environment, there is:

☐ **(1) No risk** ☐ **(2) Low risk** ☐ **(3) Moderate risk** ☐ **(4) High risk**

that the current living environment is inadequate to support the client.

4. ACTIVITIES/SOCIAL ENVIRONMENT

☐ **This module Not assessed**

A. Client Activities: (Check one)

☐ Primarily solitary
☐ Primarily with friends/family
☐ Primarily with group/club
☐ Unknown

B. How often does the client go out of the house/building to activities? (Check one)

☐ daily ☐ weekly ☐ monthly ☐ seldom ☐ never ☐ unknown

C. How often does the client have visitors? (Check one)

☐ daily ☐ weekly ☐ monthly ☐ seldom ☐ never ☐ unknown

D. How often does the client have telephone contact with others? (Check one)

☐ daily ☐ weekly ☐ monthly ☐ seldom ☐ never ☐ unknown

☐ Yes ☐ No ☐ Unknown → E. **Client has someone to talk to about problems/confide in.**

☐ Yes ☐ No ☐ Unknown → F. **Client is satisfied with current level of socialization.**

☐ Yes ☐ No ☐ Unknown → G. **Pets are important to this client.**

☐ Yes ☐ No ☐ Unknown → H. **Pets must be considered in care planning.**

☐ Yes ☐ No ☐ Unknown → I. **Religion is important to this client.**

J. Religious Affiliation: (Check one)

☐ Protestant	☐ Hindu	☐ None
☐ Catholic	☐ Muslim	☐ Atheist
☐ Jewish	☐ Buddhist	☐ Unknown
☐ Other _____		

K. COMMENTS SECTION - ACTIVITIES/SOCIAL ENVIRONMENT:

- **Describe activities (social or physical) the client enjoys**
- **Who does/can the client talk to/confide in about problems**

_____

_____

_____

_____

Risk Determination ACTIVITIES/SOCIAL ENVIRONMENT:

Based on this assessment of the client's Activities/Social Environment, there is:

☐ **(1) No risk** ☐ **(2) Low risk** ☐ **(3) Moderate risk** ☐ **(4) High risk**

that the client's social environment and activities affect the ability to care for him or herself.

5. Instrumental ADL's

☐ **Module Not assessed** ☐ **Self Reported** ☐ **Caregiver Reported** ☐ **Observed**

A. Laundry:
☐ independent
☐ supervised/ min assist
☐ moderate assist
☐ max assist/ total care

B. Housework:
☐ independent
☐ supervised/ min assist
☐ moderate assist
☐ max assist/ total care

C. Preparing meals:
☐ independent
☐ supervised/ min assist
☐ moderate assist
☐ max assist/ total care

D. Transportation:
☐ independent
☐ supervised/ min assist
☐ moderate assist
☐ max assist/ total care

E. Shopping:
☐ independent
☐ supervised/ min assist
☐ moderate assist
☐ max assist/ total care

F. Ability to stay alone:
☐ independent
☐ supervised/ min assist
☐ moderate assist
☐ max assist/ total care

G. Use of telephone:
☐ independent
☐ supervised/ min assist
☐ moderate assist
☐ max assist/ total care

H. Ability to manage money:
☐ independent
☐ supervised/ min assist
☐ moderate assist
☐ max assist/ total care

I. Ability to meet routine health needs:
☐ independent
☐ supervised/ min assist
☐ moderate assist
☐ max assist/ total care

J. Ability to meet special health needs:
☐ independent
☐ supervised/ min assist
☐ moderate assist
☐ max assist/ total care

COMMENTS SECTION - IADL's:

Risk Determination IADL's:

Based on this assessment of the client's abilities in IADL's, the client is at:

☐ **(1) No risk** ☐ **(2) Low risk** ☐ **(3) Moderate risk** ☐ **(4) High risk**

to meet his or her own living needs in the current environment.

6. SOCIAL BACKGROUND

☐ **This module Not assessed**

A. Education: **Highest Grade completed?** (Check one)

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 ☐13 ☐14 ☐15 ☐16 ☐Other ☐Unknown

B. Employment History (Check one)

☐ Employed most of life ☐ Scattered work history ☐ Housewife most of life
☐ Never worked outside home ☐ Unknown

C: Significant life circumstances (Check all that apply)

☐ Homeless/transient much of life ☐ History of alcoholism/drug abuse ☐ History of mental illness
☐ Dysfunctional family relationship ☐ Inappropriate socialization ☐ Survivor major illness
☐ The Depression was significant ☐ Holocaust survivor ☐ Victim of abuse
☐ Perpetrator of abuse

D. Significant client losses (Check all that apply)

Has client had any losses or other events in past 5 years that upset him/her very much?

☐ Loss of spouse ☐ Loss of child ☐ Loss of other caregiver
☐ Move of residence ☐ Illness/ injury ☐ Unknown

COMMENTS SECTION - SOCIAL BACKGROUND:

- **List primary Occupation and significant employment history.**
- **Discuss significant life events**
- **Discuss significant client losses which upset him/her.**
- **Discuss both client and family/caregiver preferences for receiving care.**

Risk Determination SOCIAL BACKGROUND:

Based on this assessment of the client's social background there is:

☐ **(1) No risk** ☐ **(2) Low risk** ☐ **(3) Moderate risk** ☐ **(4) High risk**

that these events would have a significant impact on care giving options.

7. MENTAL HEALTH EVALUATION

☐ **This module Not assessed**

A. PSYCHIATRIC HISTORY:

☐ treated for "nerves" or "nervous breakdown" in past 2 years
☐ hx of depression, bipolar/manic depression, or psychotic disorders
☐ hx of drug or alcohol misuse
☐ on psychotropic meds currently
☐ previously took psychotropic meds
☐ is under care of psychiatrist or other mental health professional
(Name:_____)
☐ hx of inpatient psychiatric care (date(s) and
place(s)_____

_____

☐ possible memory impairments **(proceed with Mini Mental eval)**

B.

Max score:	Patient score:	"MINI- MENTAL STATE" Evaluation
5		**Orientation:** What is the (Year?___) (season?____) (date?____) (day?_____) (month?_____)
5		Where are we? (state?_____) (county?_____) (town/city?_____) (hospital/place?_____) (floor/unit/room?_____)
3		**Registration:** Name 3 objects (book, pencil, ball). 1 second to say each. Ask patient to repeat all 3. Give 1 point for each correct answer. Repeat until patient can repeat all 3. dvise patient to remember them. Count trials and record_____.
5		**Attention and calculation:** Ask patient to count backwards subtracting 7 from 100 (100, 93, 86, 79, 72, 65) OR ask patient to spell WORLD backwards. (DLROW)
3		**Recall:** Ask for the 3 objects named above in registration section. Score 1 point for each remembered object.

9		**Language:** Point to your pencil/pen and your watch and ask for it's name. (1 point for each correct) Repeat the following saying: **"No ifs, ands, or buts"** (1 point if repeated correctly) Follow this command: "Take this paper in your right hand (1 point), fold it in half (1 point) and throw it on the floor (1 point) Hand client sign that says "CLOSE YOUR EYES". Ask client to read it and do it. (1 point) Write any sentence. (1 point) Copy simple geometric design (1 point)
30		
Total possible:	Patient total:	Assess level of consciousness along a continuum: (mark "x" along bar) _____ alert drowsy stupor coma

**** if client cannot perform any individual task due to disability indicate here:

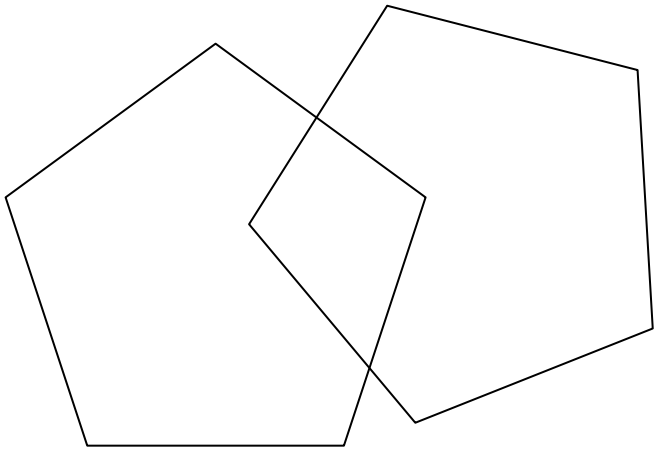
_____

_____

CLOSE YOUR EYES.

WRITE A SENTENCE

COPY DESIGN



C. Behavioral symptoms, factors and observation that impact care needs:

- ☐ none
- ☐ forgetful, easily confused
- ☐ wanders (inside)
- ☐ wanders (outside)
- ☐ at risk for financial exploitation
- ☐ at risk for physical exploitation or abuse
- ☐ frequently calls 911 w/o merit
- ☐ socially inappropriate behaviors
- ☐ public disrobing
- ☐ rummages
- ☐ hoards items
- ☐ public masturbation
- ☐ sexual preoccupation with self
- ☐ sexual preoccupation with opposite sex
- ☐ sexual preoccupied with same sex
- ☐ sexually active
- ☐ impaired judgement
- ☐ impaired decision making capability
- ☐ inattentive cooking
- ☐ careless smoking
- ☐ drinks alcohol to excess
- ☐ public drunkeness
- ☐ threatens physical aggression
- ☐ acts out aggression
- ☐ self abusive
- ☐ exhibits difficulty getting along with others
- ☐ has criminal history
- ☐ under jurisdiction of penal system
- ☐ uses marijuana or other illegal drugs
- ☐ IV drug abuser
- ☐ unsafe in current environment
- ☐ needs close or 1:1 observation
- ☐ needs soft physical restraints
- ☐ needs leather/locked physical restraints
- ☐ other _____

D. COMMENTS SECTION - MENTAL HEALTH:

_____

_____

_____

_____

Mental health summary:

☐ no mental health issues evident
☐ mental or behavioral issues may affect care options
☐ mental health status needs further evaluation: referred to:_____

Risk Determination MENTAL HEALTH:

Based on this assessment of the client's mental health factors, there is:

☐ (1) No risk ☐ (2) Low risk ☐ (3) Moderate risk ☐ (4) High risk

that the client's mental health has a significant impact on care giving options.

*** Client's scored at high risk should be referred to nurse for expanded psychiatric assessment.**

D. EXPANDED PSYCHIATRIC ASSESSMENT:

Client Interview ☐ client participated ☐ observation only ☐ combined observation/medical record review

Appearance: ☐ appropriate grooming ☐ disheveled ☐ casual ☐ neat ☐ bizarre ☐ other _____

Motor activity: ☐ appropriate ☐ restless ☐ agitated ☐ mannerisms ☐ tics ☐ posturing ☐ psychomotor retardation ☐ other _____

Sociability: ☐ average ☐ friendly ☐ open ☐ aloof ☐ negativistic ☐ ingratiating ☐ other

Character traits: ☐ grumpy ☐ suspicious ☐ stubborn ☐ cantankerous ☐ irritable ☐ demanding ☐ domineering ☐ subservient ☐ other _____

Affect: ☐ appropriate ☐ inappropriate ☐ flat ☐ blunt ☐ labile ☐ constricted ☐ calm ☐ anxious ☐ elated ☐ depressed ☐ sad ☐ hopeless ☐ hostile ☐ angry ☐ other _____

Mood: ☐ normal ☐ passive ☐ passive/aggressive ☐subdued ☐ guarded ☐ irritable ☐ guilty ☐ euphoric ☐ other _____

Orientation: ☐ oriented to time ☐ oriented to place ☐ oriented to person ☐ not oriented to time ☐ not oriented to place ☐ not oriented to person

Attention span: ☐ normal ☐ impaired **Concentration:** ☐ normal ☐ impaired

Speech: ☐ coherent ☐ incoherent ☐ relevant ☐ irrelevant ☐ flight of ideas ☐ pressured ☐ blocked ☐ mute ☐ slurred ☐ perseveration ☐ loose associations ☐ neologisms ☐ other _____

Speech content: ☐ no impairment ☐ speaks of auditory hallucinations ☐ speaks of visual hallucinations ☐ delusions ☐ ideas of reference ☐ obsessions ☐ compulsions ☐ preoccupations ☐ other_____

Intellectual function/comprehension: ☐ intact ☐ impaired ☐ adequate ☐ inadequate ☐ not assessable

Sleep patterns: ☐ sleeps well ☐ early morning awakening ☐ frequent nightmares ☐ naps ☐ insomnia ☐ sleep walks ☐ no recent change in sleep pattern

Energy level: ☐ diminished in past several weeks or months ☐ about the same ☐ full of energy/more so than normal ☐ wide variations

Judgement/decision making capability: ☐ normal ☐ impaired ☐ has legal guardian ☐ recent episodes of poor judgement ☐ other _____

Insight: ☐ good ☐ partial ☐ absent ☐ denial ☐ unable to assess

COMMENTS SECTION - EXPANDED PSYCHIATRIC EVALUATION:
Indicate suicidality, issues that must be addressed, recommendations for followup care,etc.

Risk Determination EXPANDED MENTAL HEALTH:

Based on this assessment of the client's mental health, there is:

☐ **(1) No risk** ☐ **(2) Low risk** ☐ **(3) Moderate risk** ☐ **(4) High risk**

that the client's mental health has a significant impact on care options.

[redacted]

8. FINANCIAL RESOURCES AND CARE MANAGEMENT

☐ **This module Not assessed**

A. MONTHLY GROSS INCOME: List totals by source:

Source	Client	Spouse	Verification
Earnings from employment	$	$	
Social Security	$	$	
SSI	$	$	
Disability payments	$	$	
Retirement pension	$	$	
V.A. benefits	$	$	
Regular assistance from others	$	$	
Interest income	$	$	
Rental Income	$	$	
Other/specify	$	$	
TOTAL (Client Only) (System Calculated)			

(System Calculated) ☐ Below SSI ☐ Below AFC ☐ Medicaid LTC or below ☐ Above Medicaid LTC

B. RESOURCES: List totals by source:

Source	Client	Spouse	Verification
Checking account	$	$	
Savings account	$	$	
Certificates of Deposit	$	$	
Money Market Accounts	$	$	
Real estate (other than own home)	$	$	
Savings bonds	$	$	
Trusts	$	$	
Life insurance (cash value)	$	$	
Burial plan	$	$	
Other/specify	$	$	
TOTAL (Client Only) (System Calculated)			

(System Calculated) ☐ $2,000 or below ☐ $2,001 to $15,000 ☐ $15,001 to $30,000 ☐ Above $30,000

C. HEALTH INSURANCE (Check all that apply)

☐ Medicaid SSI related
☐ Medicaid AFDC related
☐ Medicaid LTC program
☐ Medicaid: unknown program
☐ VA
☐ Medicare A
☐ Medicare A & B
☐ Medicare A & B & supplemental
☐ Other insurance: hospital
☐ Other insurance: unknown benefits
☐ none
☐ unsure/unknown

Medicaid# _____ Medicare# _____ QMB/SLIMB# _____

VA # _____ Other # (specify) _____

D. FINANCIAL / LEGAL MANAGEMENT:

Financial / Legal Assistance ☐ None ☐ Unknown (Check all applicable - Specify who in text):

☐ Guardian person	☐ PoA property	☐ Lawyer
☐ Guardian property	☐ Durable PoA person	☐ Informal responsibility delegated to:
☐ Guardian both P&P	☐ Rep payee	_____

E. ADVANCE DIRECTIVES ☐ None ☐ Unknown **(OR Check All That Apply):**

☐ Living will: dated _____ ☐ Durable PoA for health care ☐ Do Not Resuscitate ☐ Organ donor

F. MONTHLY EXPENSES: List dollar amounts:

$_____	Rent/mortgage	$_____	Utilities	$_____	Clothing
$_____	Food	$_____	Medication/medical	$_____	Other
$_____	Telephone	$_____	Insurance		

G. CLIENT EXPENSES = (System Calculated)

☐ < 1/2 monthly income ☐ = 1/2 to 3/4 monthly income ☐ = monthly income ☐ > monthly income

COMMENTS SECTION - FINANCIAL:

_____

_____

_____

_____

_____

COMMENTS SECTION - CARE MANAGEMENT:

_____

_____

_____

_____

_____

Risk Determination FINANCIAL RESOURCES AND CARE MANAGEMENT:

Based upon this assessment, the client's financial situation and care management puts him or her at:

☐ **(1) No risk** ☐ **(2) Low risk** ☐ **(3) Moderate risk** ☐ **(4) High risk**

to need financial or legal assistance to support care needs.

9. INFORMAL SUPPORTS/CAREGIVERS

☐ **This module Not assessed**

A. CLIENT HAS INFORMAL SUPPORTS? (Check One) ☐ Yes ☐ No ☐ Unknown

List informal supports below. Note primary caregiver with designation "P"

Prim.	Name and relationship	Location	Phone	Help Provided

B. LIMITATIONS OR CONSTRAINTS ON PRIMARY CAREGIVER (Check ALL that apply) :

☐ None
☐ Poor relationship with client
☐ Poor health, disabled, frail
☐ Lives at a distance
☐ Employed out of home
☐ Alcohol/drug abuse
☐ Lacks skills knowledge
☐ Financial strain
☐ Providing care to others
☐ Dependent on client for housing, money, other
☐ Not reliable
☐ Perptrator of abuse
☐ Other
☐ Unknown

C. Overall how burdened does the primary caregiver feel in caring for the client? (Check one) :

☐ not burdened ☐ somewhat burdened ☐ very burdened ☐ unknown

D. The Caregiver desires service or support (Check one) :

☐ Yes ☐ No ☐ Unknown

E. The client's other informal supports are (Check one) :

☐ Weak ☐ Strong ☐ Unknown

F. The client's other informal supports (Check one) :

☐ Can continue ☐ Can not continue ☐ Will need support/coordination in order to continue ☐ unknown

COMMENTS SECTION - INFORMAL SUPPORTS/CAREGIVER:

- **Ability of the informal supports/caregivers to meet the client's physical and emotional needs**
- **Describe problems with continued caregiving**
- **List any circumstance presenting a danger to client, formal caregiver or informal caregivers**

_____

_____

_____

_____

_____

Risk Determination INFORMAL SUPPORTS/CAREGIVER:

Based on this assessment of the clients informal support system there is:

☐ **(1) No risk** ☐ **(2) Low risk** ☐ **(3) Moderate risk** ☐ **(4) High risk**

that these supports are inadequate to meet the client's needs.

10. FORMAL SUPPORTS

☐ **This module Not assessed**

A. CLIENT HAS FORMAL SUPPORTS OR PAID SERVICES IN PLACE: ☐ yes ☐ no ☐ unknown

List formal supports and/or paid services below using the following codes:

Status codes: C= current O= ordered but not yet started P= received in past 6 months R=recommended

Method of payment codes: S= self pay MC= Medicare MA= Medicaid O= other insurance F= family contribution BG= SSBG 3=Title III U= unknown

Frequency codes: D= daily 5x= Monday through Friday 4x= 4 times per week 3x= 3 times per week 2x= twice a week 1x= weekly 2xM= twice a month M= monthly PRN= as needed U=unknown

Service Type:	Status:	Payment:	Frequency:	Provider (if known)
Adult day care				
Assisted living facility				
Attendant care (personal and/or homemaker)				
Case management				

Mental health counseling/ outpatient psychiatric care				
DAST/ paid transportation				
Day habilitation/ training program				
Financial management (help w/ bill paying, banking, MA application, etc)				
Home delivered meals				
Home health aide (personal care, bathing, walking, eating,etc)				
Home maintenance (yard work, adaptations, snow removal, other heavy chores)				
Homemaker (meal prep, light housecleaning, laundry, shopping, etc)				
Hospice care				
Job counseling/ supported employment/ voc rehab				
Legal services (PoA, etc)				
Medication preparation or administration				

Service Type:	**Status:**	**Payment:**	**Frequency:**	**Provider (if known)**
Nursing home care				
Nutritionist/dietitian				
Rest/residential care or foster care				
Skilled nursing care or services or supervisory visits				
Occupational therapy				
Ombudsman				
Partial hospitalization				
Physical therapy				
Protective Services				
Respite care- in home				
Respite care- in facility				
Senior center				
Speech therapy				
other:				
other:				

COMMENTS SECTION - FORMAL SUPPORTS:

_____

_____

_____

Risk Determination FORMAL SUPPORTS:

Based on this assessment, the lack of formal supports puts the client at:

☐ **(1) No risk** ☐ **(2) Low risk** ☐ **(3) Moderate risk** ☐ **(4) High risk**

to meet his or her own care needs in a community based environment.

11. CONCLUSION Client needs, significant planning factors, final decision:

A. Basic care needs:

☐ none
☐ housekeeping assist
☐ personal care assist
☐ IADL assist
☐ meal preparation/cooking
☐ emergency response
☐ exercise/supervised activities
☐ ADL assist
☐ Attendent care
☐ bowel/bladder assist
☐ transfer/mobility assist
☐ oral med prep/admin
☐ stable insulin injection
☐ routine colostomy care
☐ routine oxygen admin
☐ non sterile dressings
☐ durable med equipment/supplies
☐ 24 hr supervision for safety
☐ body fluid precautions
☐ wound/skin precautionss
☐ private room
☐ other _____

B. Skilled nursing needs:

☐ none
☐ NG tube feeding
☐ PEG tube feeding
☐ IVs, PICC, central line
☐ IM, SC or IV injections
☐ hemodialysis shunt check
☐ peritoneal dialysis
☐ Decub care (stage 3 or 4)
☐ Daily sterile drsg change
☐ Nasopharyngeal suction
☐ trach care
☐ ventilator care
☐ Insert/change catheter
☐ Treat/change colostomy
☐ 24 hr skilled obsv/intervention
☐ patient/caregiver education
☐ strict isolation
☐ reverse isolation
☐ respiratory isolation
☐ other _____

C. Skilled allied health needs:

☐ none
☐ skilled PT, eval and treat
☐ gait eval/training
☐ active range of motion
☐ ultrasound, massage rx.
☐ whirlpool rx.
☐ transfer training
☐ maintenance PT
☐ OT eval and/or treatment
☐ speech therapy
☐ dsyphagia/swallow eval or treatment
☐ respiratory therapy
☐ other _____

ASSESSMENT RISK AND IMPACT ON FINAL DETERMINATION: (do not repeat data recorded in individual assessment sections; document how the associated risk led you to your conclusion)

1: PHYSICAL HEALTH **Risk: ___**

Impact:

_____

_____

_____

2: A D L 's **Risk: ___**

Impact:

_____

_____

_____

3: ENVIRONMENT **Risk: ___**

Impact:

_____

_____

_____

4: ACTIVITIES & SOCIAL ENVIRONMENT **Risk: ___**

Impact:

_____

_____

_____

5: I A D L 's **Risk: ___**

Impact:_____

_____

_____

6: SOCIAL BACKGROUND **Risk: ___**

Impact:_____

_____

_____

7: MENTAL HEALTH **Risk: ___**

Impact:_____

_____

_____

8: FINANCIAL RESOURCES **Risk: ___**

Impact:_____

_____

_____

9: INFORMAL SUPPORTS & CAREGIVERS Risk: ___

Impact:_____

_____

_____

10: FORMAL SUPPORTS & PAID SERVICES Risk: ___

Impact:_____

_____

_____

11: MEDICAL DETERMINATION

Based on this assessment & medical report from attending physician:

☐ **client is not medically eligible for long term care services**

- ☐ foster care or rest/residential care is recommended
- ☐ assisted living facility is recommended
- ☐ PASARR determination concluded client is not medically eligible
- ☐ HCBS no longer appropriate but client refuses nursing home
- ☐ client must be discharged from nursing home
- ☐ other _____

☐ **client is medically eligible for the following long term care services**

- ☐ HCBS in lieu of nursing home care is recommended
- ☐ nursing home admission (long term) is recommended
- ☐ nursing home admission (short term) is recommended
- ☐ HCBS no longer appropriate, nursing home admission is necessary
- ☐ continued nursing home placement is necessary
- ☐ PASARR determination concluded client is medically eligible
- ☐ other _____

Nurse:_____Date:_____

12. LEVEL OF CARE DETERMINATION:

Approved for:

☐ Adult foster care (rest/residential care)

☐ ICF facility level of care

☐ SNF facility level of care

☐ ICF home/community based care pending care plan development

☐ SNF home/community based care pending care plan development

Nurse: _____Date:_____